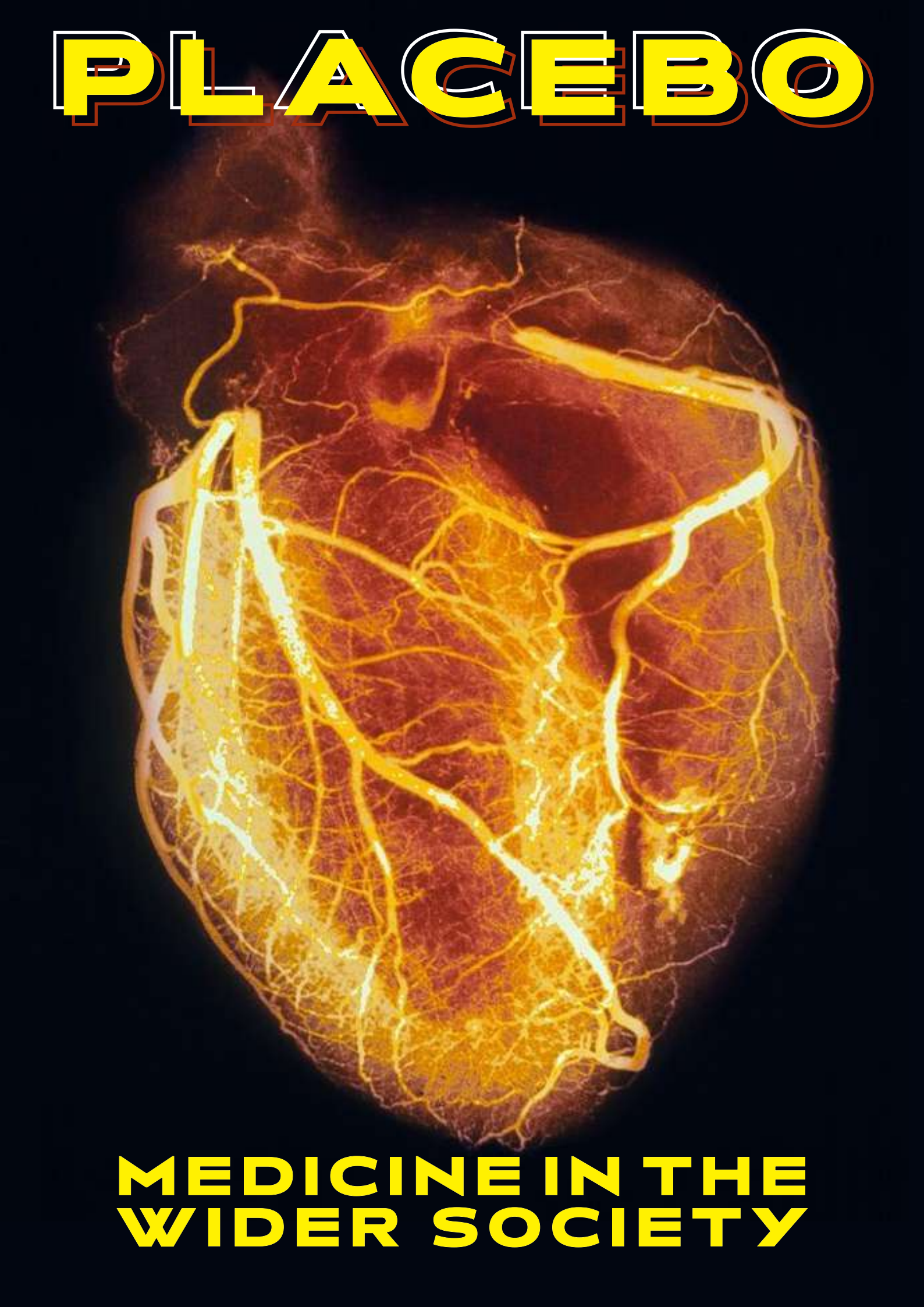
PLACEBO



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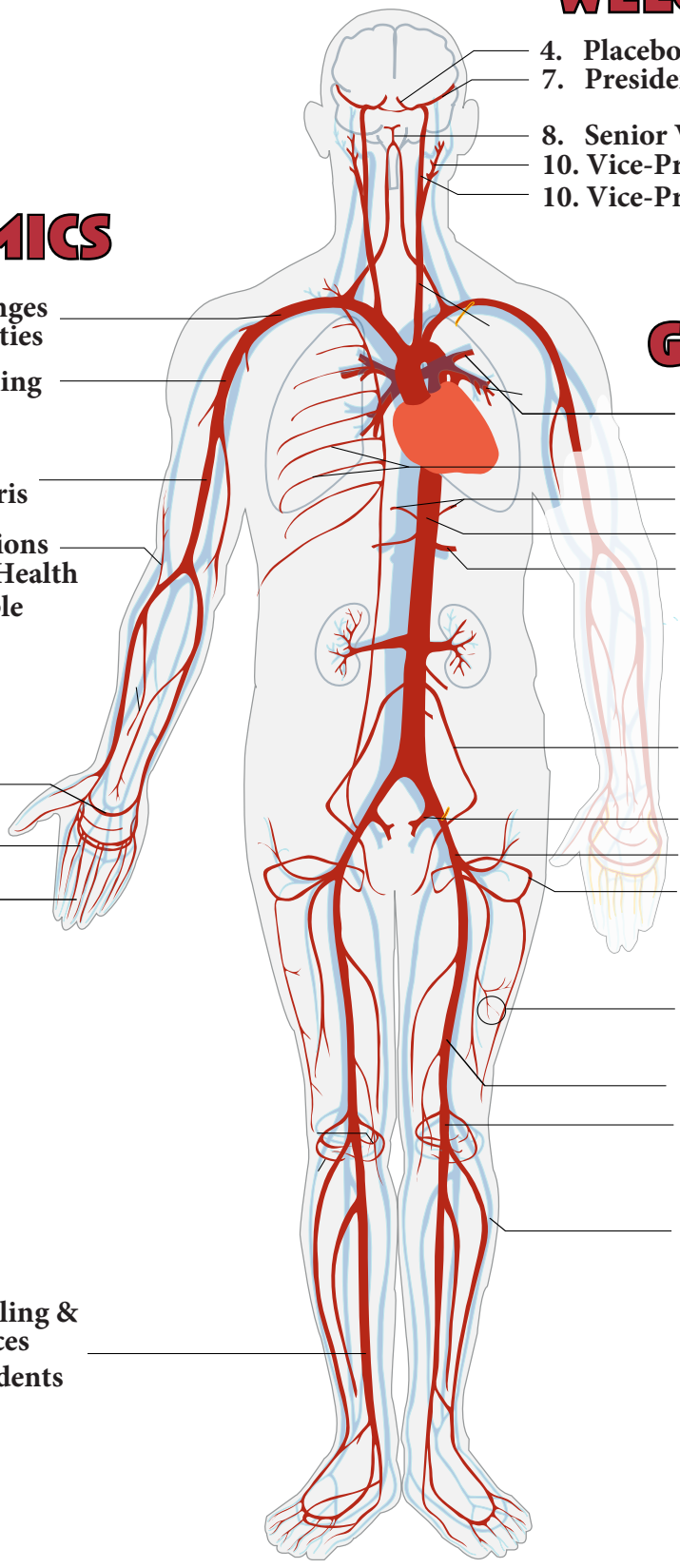

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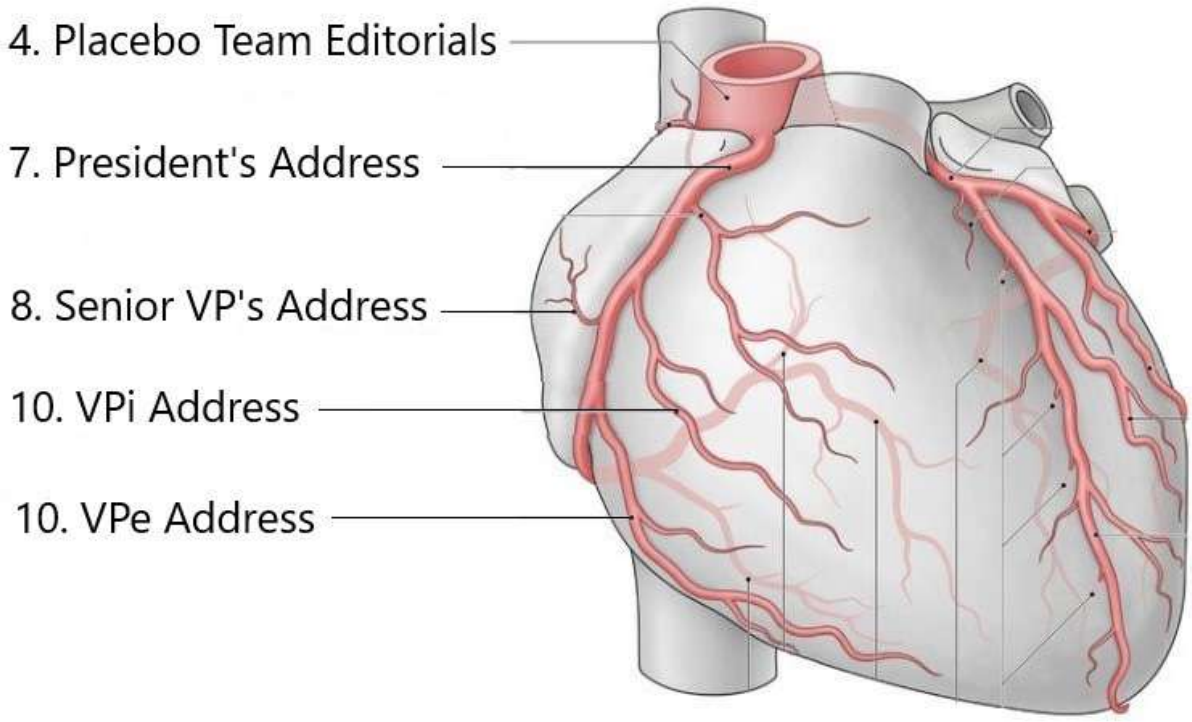
SOCIAL

WELCOME



PLACEBO TEAM EDITORIALS

YSABELLA TYLLIS

MD2, FMSS Director of Publications

Hello! My name is Ysabella, your 2019 FMSS Director of Publications. Putting this issue of Placebo together for you has been one of the most challenging yet rewarding experiences I have encountered (quite like the Medical degree itself!). While navigating the process of creating and editing this magazine, I have had the chance to reflect on the medical career, and where we stand in the wider picture. Medicine influences and is influenced by many things – climate change, public health, world politics, war, economics. We are constantly adapting techniques, procedures and priorities to fit the ever-changing environment that our work and research may be in. Some clinicians prefer the challenge of an ever-changing or unexpected environment, and some dedicate their careers to understanding our role in environmental change. Without clinicians that go above and beyond the medical norm of hospital and clinic work, our field of work would not be nearly as advanced as it is today. This issue of Placebo encompasses some of the many areas that this wonderful (and slightly terrifying) career can take you, and some places outside of the hospital that you might not expect to find yourself or your peers. It has been an absolute pleasure to have worked alongside my publications and marketing teams to bring to you articles from doctors with a world of experience. Thank you to everyone that made this issue possible!

So, sit back with your cuppa, relax, and enjoy this issue of Placebo as much as we enjoyed bringing it to you.

SAI LEKSCHMI CHANDRAMOHAN

MD1, Publications Officer

Hello, and welcome to the first issue of Placebo for 2019 - Medicine in Wider Society. It has been an absolute privilege to be involved in the making of this issue. As medical students, so much of our time is spent studying the intricate details of pathology and clinical communication. Yet, if we observe our collective aspirations at its roots, it is hinged on making the world a better, healthier place. This is precisely the focus of Medicine in Wider Society: to bring back a sense of balance in our responsibilities to the individual patient and the global population.

We are now constantly solving problems for issues that were non-existent a decade ago. The global medical community has made strides in rural, public and global health endeavours. Still, there are numerous concerns regarding the health status of refugees, underprivileged communities and those that are vulnerable within our society. In the coming decades, we will face many more seemingly insurmountable challenges, including the effects of climate change on the environment and public health. These are not issues that you nor I can tackle alone. It is only through a multidisciplinary approach, with a sense of shared interest and interconnectedness, that we can find solutions to bring about real, practical changes. Technology-driven medical innovation, positive social media influence, and pro-sustainability campaigns are a few of many tools that we can harness to do our part as global citizens. I hope that this issue of Placebo inspires you to consider how you might do your part for the wider society both now and into the future. Enjoy!

JULIO DOMINGUEZ

MD1, Publications Officer

It is with great enthusiasm that I step into the role of Publications Officer, and I hope that in the next months and hopefully years, I'll be able to translate my enthusiasm and passion into great informative writing. Medicine is a challenging degree – it asks a lot from us. It is not a career path for someone who wants to work 9-5, go home, and forget their work. It's a career that demands a lot from a person and involves the acceptance of lots of responsibility in the community. When you are a doctor in society, there are expectations that society places on you. That can include things like being willing and prepared to provide emergency care in any situation, to always being expected to act in a professional manner no matter the occasion. It's not a job where you can just switch off when you clock off – you must always be aware of your responsibilities.

That said, Medicine is also a unique career in that it can allow you the opportunity to truly make a difference in the communities you live in. Your skills directly impact the lives of others, and your actions can bring much happiness to people. We are getting into a career that is ultimately for the service of others, and we must always remember that. Your decisions will inevitably impact the lives of your patients, and we must remain diligent and humble in our work.

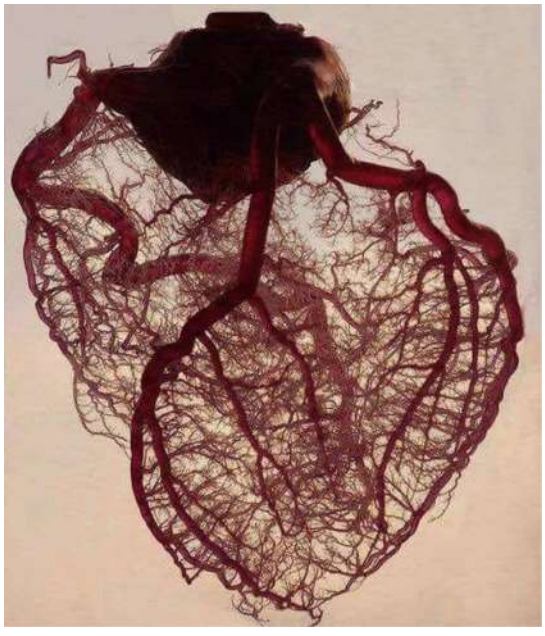
We have such a great and supportive atmosphere at Flinders. It's such a privilege to be able to share experiences with such a talented and friendly cohort, and I'm looking forward to seeing how the next four years pans out. It's important to remember that we are never alone in our journey, and that we all bear the same responsibilities. It can be easy to get overwhelmed or scared, and it's ok if even the smallest things scare you, but Medicine is no doubt an extremely noble career choice and those who make it through will surely be rewarded with life-changing experiences.

RICKI BYAS

MD2, FMSS Director of Marketing

When I put my hand up to be the FMSS Director of Marketing for this year, it was with both excitement and trepidation, and in no small part due to Ysabella's pressure. I had really enjoyed all the posters and Placebo issues last year but had zero experience in using any of the software. Hence putting together this issue of Placebo started with very little progress and oh so much venting my frustrations with InDesign towards the Director of Publications. It took me 20 minutes to figure out how to change the colour of font, another to discover that you can't just bold text, but have to select the bolded version of the font, and don't even get me started on the fact the pictures have 2 image boxes to adjust! I should've just done the tutorial on it, but I had decided I didn't have time and I surely could figure it out easily on my own. All I can say to that is, hindsight is a wonderful thing.

For this issue, I had thoughts about the front cover being something like an iceberg or a tree with all the roots burrowing underground to represent medicine in the wider sense. When we think of medicine its usually just doctors and nurses in hospitals, but it truly is so much more than that, as this issue will highlight. I then had the idea of an angiogram with all the arteries leading out from the heart to portray medicine at the centre and all these peripheral aspects leading away from it. In the end, I found the image of the coronary angiogram on the cover and just thought it looked so cool! Especially with the colour scheme, as I'm used to seeing angiograms in just black and white.



Sticking with the blood theme, the textbook like contents pages then came as an idea. Each section was carefully chosen: welcome to Placebo, a piece that we've put our hearts into; brain for academics, obviously; descending aorta for opinions, to represent the gut feelings; a hand to embody giving back; and finally leg for social, because… dancing! Bonus points to anyone who can name all the arteries the different articles are pointing to! I've included another image of the coronary arteries I thought looked awesome just because. Enjoy!

ACKNOWLEDGEMENTS

As always, we would like to acknowledge our hardworking contributors. Placebo would not be possible without you.

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Kimberly Lai
Kritika Mishra
Liam McClory
Mia Shepherdson
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Nibir Chowdhury
Nick Petrakis
Nick Wan
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We would like to acknowledge the Kaurna People, the traditional custodians of the land on which Placebo is produced. We recognise their continuing connection with their country and pay respect to Elders both past and present.

WHY DO WE HAVE AEDS IN SHOPPING MALLS BUT STILL NO EFFECTIVE CLIMATE CHANGE POLICY?!?

JARROD HULME-JONES
MD4, FMSS President

As I sit and write in a café in the Adelaide Harbour Town Premium Outlet mall (oxymoron noted) the role of medicine in wider society is all around me. For Australians aren't just made healthy in the confines of tertiary hospitals and GP clinics, but also in our restaurants, airports, factories, schools and overpriced mall cafes. The perfectly flat entrance to stores in this mall allows the pleasant elderly lady wearing sunglasses indoors with a shuffling gait and a four-wheeled-walker to mosey her way into the Calvin Klein shopfront with ease. The wall-mounted Automated External Defibrillator (AED) looks on with anticipation. But how is it that so much of society started to be influenced by medicine? Why do commercial airlines stock their cabins with adrenaline? Why did my swine-flu'd family receive a directive from the government to stay in a hotel 'til they were better? In my view, the reason is at least two-fold:

A hard-won respect for the scientific method, at the heart of medicine, from society earned through centuries of being more likely to find answers to life's questions than the competing methods of superstition, tradition and guess work. I'm a Cancer in case you were wondering.

The infiltration of public offices with people who have medical or other scientific training.

And this is great! When Doris flips into ventricular fibrillation whilst trying on the latest CK underwear, I can quickly rush to her aid with an AED. But there is something that I've always found unfair about the rapid acceptance of medical discoveries and their integration into broader society. And it comes down to this: evidence-based medicine is born out of the scientific method. The very same that underpins other scientific discoveries, from the Higgs boson to climate change. Few people, and fewer western governments, baulk at or question the merits of modern medicine, nor did they take issue with the announcement of the discovery of the Higgs boson, but it is taking the Australian people and our government a looooooong time to come around to accepting the existence of climate change, its significance and its man-made origins. So why is it that a scientific discovery in one field can yield such limited societal acceptance when others that came into being using the same tenets of the scientific method with the same or less rigour are so rapidly adopted? And is there a role for those working in scientific fields with ideas that are rapidly accepted by society, read MEDICINE, to argue that people can't pick and choose which scientific discoveries to deem credible based on how they might impact their lifestyle?

From the tone of my article, you may have guessed that I think the answer is YES. Medical doctors haven't always been preachers of the scientific method- the 'bloodletting to rebalance the humors' approach of our predecessors comes to mind. But as we have decided that high quality, peer-reviewed empirical research should be the basis of clinical decision making wherever possible, we should be advocates for the scientific method outside of healthcare settings. I can't explain why some good quality scientific discoveries are rejected or ignored – every reason I think of can be countered with evidence to the contrary – but as soon-to-be doctors and trusted professionals in society, I feel a strong responsibility to publicly defend all of those discoveries proportionately to the strength of their evidence. Who knows- it might be our industry fighting for credibility in the public eye one day, and we could certainly use the help of our scientific colleagues.

Doris has moved on to the RM Williams (praise be) outlet next door. May the junior-male-doctor shoeing gods smile upon her.

VICE-PRESIDENT'S ADDRESS

DIANA HANCOCK

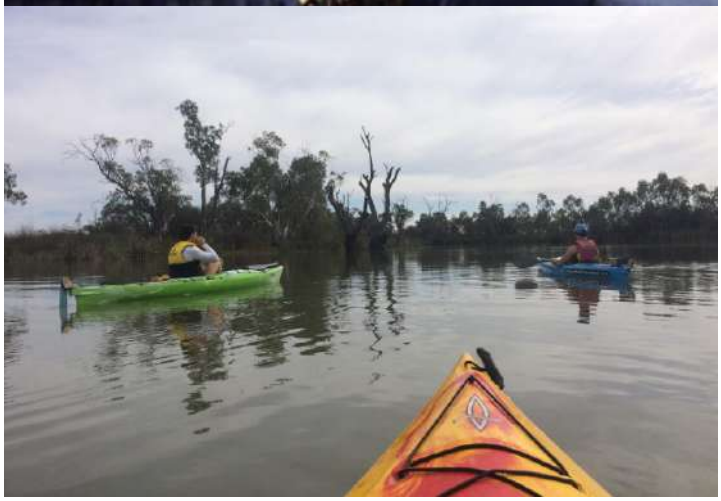
MD4, FMSS Senior Vice-President

The theme for this issue of placebo is "Medicine in the wider society". I have been lucky with my placements throughout medical school to gain exposure to a number of communities. In 2017, I did a voluntary holiday placement at the Maranatha Children's Clinic in Uganda. In third year, I was lucky enough to be part of the Riverland Parallel Rural Community Curriculum program and got to spend the year, immersed in a country town, welcomed and taught by rural doctors.

The health disparity between Uganda and Australia is huge, particularly in regards to rural access to health. In the clinic I spent time in, children had often travelled from rural areas where health literacy was low, and presented late with illnesses such as pneumonia, malaria and sickle cell crises. Countries in Sub-saharan Africa have the highest incidence of Malaria in the world. Uganda, is affected by Malaria, and yet due to low education, public health preventative messages have not been successful in this area. Only 42.8% of children sleep under mosquito nets in Uganda, and 13% of children in Uganda are considered moderately to severely underweight so it was clear to see how education and public health initiatives are so important for communities. The impact that the staff and patients in Uganda had on me, was far greater than anything I contributed, and this community and particularly the kids, have a special place in my heart.

Placement at Marantha Children's Clinic, Fort Portal, Uganda

In the Riverland, the medical education that we gained was due to the kindness and inclusiveness of both the doctors and patients that we met. We really were welcomed into the town, and for the first time I was able to see how Medicine affects the wider society in Australia as I got the chance to follow patients journey's throughout the year. We were taught by General practitioners, GP obstetricians, nurses, midwives and visiting specialists. The nice thing about being in a placement for the whole year meant that we really felt part of the community.



Photos taken during clinical simulation in Renmark and around the Riverland

At the start of 2019 I was able to do a placement in Darwin for 6 weeks in Plastic and Reconstructive Surgery, which was an amazing opportunity to meet our fellow students who are part of the Flinders NT program, and see the difference in health there.

Photo taken in Darwin, NT

All three placements have varied with the community that I was welcomed into and learnt from. Throughout Med school, it is easy to focus on the progress test as an end goal to assess where we want to be. But it is important to remember that the clinical skills we learn and the content that is taught in every lecture throughout first and second year, is aimed to prepare us for in the future, providing care to people in the wider society.

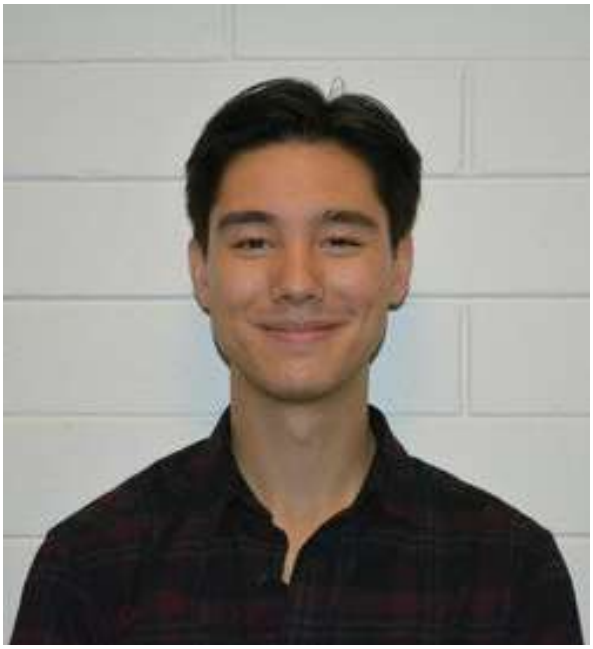
The best part of being on FMSS this year has been having the opportunity to work with the second years who are so passionate about working to help their own cohort, putting on events and raising money to help the broader community. It has also given me the opportunity to meet the new first years through FMSS's orientation and mentorship program. The new first years are already so hardworking and enthusiastic, I look forward to seeing where in the broader society, Medicine will allow them to go.

*All patient and staff photographs taken with permission

MEDICINE ET AL.

EMERSON KRSTIC

MD2, FMSS Vice President Internal



For medical students, medicine can often become about passing our next assessment or preparing madly for OSCEs, but what is medicine to the wider world, and how does that, or should that, shape the way we think about our studies?

I believe medicine in the wider community encompasses every little interaction the public has with medical practice; a spectrum, ranging from their General Practice consults all the way down to that ad that passes by fleetingly on a bus about this year's flu shots. Ultimately, this range of interactions precipitates a public perception about medicine and its role in today's society. I feel that as a student, it's easy to forget about this perception and the role that we have to play in its creation – we will be the 'on the frontline' of forging this attitude, yet how much time do we give to thinking about our impact here? Will we choose to fight to better this perception? Will we choose to be heroes… or villains?

I was also recently reminded that this big, boundless entity called 'the public' includes friends, family, and loved ones. Sometimes the wider community is closer to home than we think.

Right, that's enough, this is beginning to get way too dramatic. I believe medicine in the wider society comes down to the little things we can do in every day interactions, and that these often help in a big way, sometimes bigger than we can possibly imagine.

QUESTION FROM DARWIN

MIA SHEPHERDSON

MD2, FMSS Vice President External

Thinking of medicine outside the scope of the intricate lacunae structures of the placenta was not something I had achieved in the first 10 weeks of this semester. I was excited for a study break in Darwin over Easter with my friend Claire, a student in the Northern Territory Medical Program. Darwin was hot and the mosquitos were ruthless, Claire joked about catching Murray Valley encephalitis virus and it occurred to me how although we are in the same degree, what we knew as medicine in the wider community differed greatly. The challenges faced in a city a three hour flight north varied significantly, where the population confronted pathogens only seen by Adelaide students in the Progress Test.

The city of Darwin faded on the flight home into surrounding suburbs and smaller communities until it reached the desert. As the urbanization of the landscape decreased, so did the accessibility to healthcare. Geographical distance affects not only the types of diseases shaping our perception of the 'wider society' but also affects a population's ability to seek medical care. Caring for Australians who have less access to health care should be a major focus in our goal to understand and improve health care in the wider society. This edition of Placebo is a fantastic initiative to challenge us to consider how medicine is impacted by the environment and society in which we live.

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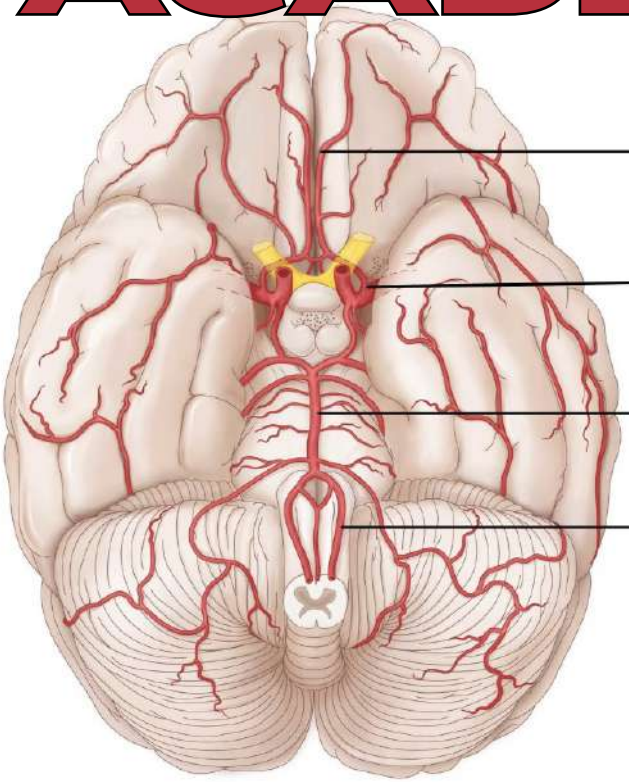

CHANGE: CHALLENGES AND OPPORTUNITIES

PROF JONATHAN CRAIG

Vice President & Executive Dean, College of Medicine & Public Health

It's a great privilege to provide a few words in "Placebo", a publication with a rich tradition of excellence and critical thought.

It's now been a year since I joined Flinders and so timely to reflect upon the changes that have occurred over that time (and prior), and the College's vision for the next year.

Change is full of paradoxes. On one hand, change is inherent in the human condition. All of us age, and hopefully mature, and the world around us surely does, whether that be climate change, technology, and how we communicate.

Healthcare is undergoing substantial change. Disciplines are becoming increasingly super-specialised. Sub-specialties have evolved rapidly, reflecting massive changes in technology and services. Instead of sub-specialists such as interventional cardiologists or transplant oncologists, we now have sub-sub-specialists who spend almost their entire time delivering a single game-changing procedure such as TAVI or CAR-T. Increasingly healthcare providers and regulators will be explicitly responsible to the end-users - patients - not only for acute care but also in shaping the research agenda. While a focus on acute care is understandable, the broader socio-economic and cultural context of health will need to be addressed if there is to be an equitable, needs-based approach to improving health and well-being at a population level.

Although change is a normative state, those affected rarely enjoy the process. Flinders has experienced substantial change in the past few years, in personnel and in structures – a new Vice-Chancellor, a new College structure, new Executive Deans in all but one College, a new model of providing professional services, and a substantially reshaped academic workforce. Within the MD program, programmatic assessment for learning and learning coaches have been introduced. These are big changes!

Why have these changes been needed? These have been required to deliver the ambitious Making a Difference: Flinders 2025 Agenda. The vision outlined "is to be internationally recognised as a world leader in research, an innovator in contemporary education, and the source of Australia's most enterprising graduates". In short, to be the best small University in Australia. We are a predominantly publicly funded institution. We take we our community responsibilities very seriously. We are here to deliver transformative education and research, which, in our College means transforming healthcare and health outcomes.

So how are we going to do that? Through an unrelenting focus on excellence, supporting our staff (who are our greatest resource), and building a culture of equity and transparency, based upon leaders who see themselves as servants and builders of teams.

In Education, within the MD program, this will mean some 'tweaks' to our assessment processes to make them more sustainable for both staff and students, and improve the consistency and clarity of communications. We will also be convening a workshop on student mental health and wellbeing to ensure that all of our staff are aware of their responsibilities and pathways for student support. The appointment of more Teaching Specialists underlines the critical importance of innovation and excellence in teaching. We are planning for a community of practice amongst our best educators so that their career development is maximized, and we have research-informed teaching practices across the College.

Flinders' defining feature is the Central Corridor, a large footprint of education and research activities from Mt Gambier in the south-east through the Riverland, Barossa, Victor Harbour, Bedford Park in South Australia and through to Alice Springs, Tennant Creek, Katherine, Darwin and Nhulunbuy in East Arnhem land. Flinders rightly is proud of its impact in rural and remote settings and our students have the privilege of doing placements in such an environment. We are in the process of integrating the SA and NT programs, with a single Rural and Remote Discipline, so that the learnings in research and education can be shared across the entire Corridor, the career development of our staff, particularly our Indigenous staff is strengthened and that our research impacts are multiplied. For our MD students, this will lead to a more standardised curriculum with academic expertise shared across the Corridor.

In Research, we are planning to launch a Flinders Health and Medical Research Institute by June. This will bring together all the world-class researchers we have into a single Institute, provide specific programs to build early and mid-career researchers in particular, and uplift our research performance. Why does this matter for MD students? At one level, there are very concrete benefits of having stronger local research capacity for Advanced Studies projects, but great researchers infuse culture and that's good for us all. They ask the right questions. They do not accept the status quo. They are seeking new knowledge. These are attributes that are delightfully contagious.

Finally, we have planned a number of activities to build capacity in our academic and professional staff, and strengthen our partnership with organisations like SALHN and Royal Darwin Hospital. Education and research are fundamentally collaborative activities.

So, in short, over the next year you will be the direct and indirect beneficiaries of many of the opportunities that change has brought to Flinders. I am very optimistic regarding the future. There is no reason why Flinders cannot be the best small university in Australia, and you, the best medical graduates in Australia. That is our ambition. My sense is that this is your ambition too and we are increasingly working together to achieve that end. I am looking forward to my second year at Flinders very much.

MEDICAL WORDSEARCH

Alzheimers
Ambulation
Aorta
Arteries
Arthritis
Atrium
Benign
Birth
Cancer
Cardiogram
Cardiologist
Constipation
COPD
Dentition
Depression
Diabetes
Diagnosis
Diarrhea
Disease
Dyspnea
Erythrocytes
Fracture
Glaucoma
Gynecologist
Handwashing
Intravenous
Malignant
Mortality
Myasthenia
Myocardium
Neurologist
Oxygen
Patient
Phlebotomy
Prognosis
Psychiatrist
Pulmonary
Sclerosis
Surgeon
Surgery
Tachycardia
Treatment
Vascular
Veins
Ventricles

Note: Apologies for the American spelling

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WHAT IS THIS THING CALLED PUBLIC HEALTH?

DR ROBERT HALL

State Education Coordinator for AFPHM

I have recently been involved in redeveloping the public health component of Years 1 and 2 of the MD course. This has been an interesting exercise, to try to figure out what medical graduates should know about public health. It's been more difficult because it helps a great deal to have some clinical background, and students in the early years haven't had time to develop that expertise. I decided that the teaching should give students an idea of

1. what public health is,
2. the state of health currently in Australia and how we measure it,
3. communicable disease control and the role clinicians play in it,
4. immunization,
5. chronic diseases control and health promotion,
6. social determinants as important drivers of the state of health, and
7. how we make decisions in public health.

Essentially, I drew these ideas from my experiences as a state Director of Public Health and Chief Health Officer.

Another objective was to get students to think about public health as a possible career. Clinical medicine can be very satisfying, with its intellectual challenges and the engagement with patients. Public health is equally intellectually challenging, but has different rewards---sometimes on a grand scale. Public health covers an enormous variety of work.

I started my career in remote Aboriginal health. I spent some time working for an Aboriginal health service some 250km out of Alice Springs. There were about 600 people living in 13 small outstation communities, speaking 2 different Australian languages, and with 2 different cultural systems. One of the things we did was quintessential old style public health: we arranged for the installation of toilets and showers in small outstation communities. We worked with appropriate technology experts who had designed low cost, low-maintenance facilities which small communities could take ownership of and look after themselves. I worked with Aboriginal Health Workers who practised a mix of traditional and western medicines. Working in this environment brought me face-to-face with social determinants, and how the circumstances of life strongly drive the state of health. This was a formative experience and has influenced my career ever since.

I undertook a public health training scheme in Sydney where I worked in community health in the inner city, and then environmental health south of the Harbour. I worked on my first outbreak---4 cases of typhoid spread by a food handler who didn't know she was a carrier. The disease detective process was so interesting I decided that I wanted to make this my career.

I became Director of Communicable Diseases in the federal Department of Health. It was a good time to be there, because we were able to set up the National Notifiable Diseases Surveillance System. Before then there had been no systematic collection of communicable diseases surveillance data on a national basis. We also laid the groundwork for the National Immunisation Program, which was based on the National Immunisation Strategy which we wrote. This led to the establishment of the Australian Immunisation Register and a massive improvement in the immunization programme. Ultimately this led to the elimination of indigenous measles in Australia, so that all cases of measles now originate in infections brought in from overseas.

In the 1990s I was Director of Communicable Disease Control for the South Australian Department of Health. A major part of this work was outbreak investigations. Our largest outbreak was salmonella associated with orange juice, where we had 512 cases over a month or so. We were able to identify the source using a case-control epidemiological investigation within 10 days of first recognizing the outbreak. The other activity I remember from that time is the continual effort to respond to cases of invasive meningococcal disease. This meant interviewing cases or their relatives at any time of the day or night to organize clearance antibiotics to minimize the spread of infection. Communicable disease control doesn't sleep, and I think I worked every Christmas Day during that time.

Later I became Director of Public Health in Victoria. This was a big and politically charged responsibility. I had a budget of $350 million and a staff of 250. We covered communicable and non-communicable disease control and prevention, environmental health, radiation protection, cemeteries, smoking and drug control---a very wide range of services. We helped draft the new Public Health Act, and brought in such ideas as health impact assessments and state and municipal public health plans.

Also, I was chair of the Technical Advisory Group on Immunization and Vaccine-Preventable Diseases for the Western Pacific Region of the World Health Organization. We provided guidance to WHO and assistance to countries in the Region to eliminate polio, and set targets to eliminate hepatitis B, measles and rubella. We eliminated polio in 1998, with the last case being in Cambodia. We planned to eliminate measles by 2012, but have not yet been successful across the Region, although several countries, including Australia, have reached this target. Hepatitis B elimination is ahead of schedule. When we started about 10% of children in the Region had acquired hepatitis B by the age of 5; the figure is now <1%.

This has been an incredibly satisfying career. My class at medical school held our 40th anniversary reunion last year and I felt that I had been lucky enough to contribute a huge amount to health, and perhaps more than many of my classmates. Although you don't get the immediate satisfaction of seeing patients in public health, and you have the joys and frustrations of working for the government, it is possible to reflect back on important contributions you have made to improve health in many different places. Public health medicine is a recognized specialty, with the Australasian Faculty of Public Health Medicine as a specialized group within the Royal Australasian College of Physicians. There is a 4-year workplace-based advanced training programme after completing a Master of Public Health degree. I am the State Education Coordinator for the AFPHM, and if you are interested please get in touch.

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INTERVIEW WITH DR RICHARD HARRIS

AUSTRALIAN OF THE YEAR 2019

Specialist Anaesthetist, Medical Retrieval Consultant

I wanted to find out more about your experiences in wilderness, remote and retrieval medicine. Tell me a little about your journey - what has lead you to where you are now?

When I left school, I came to Flinders University, as you know, to study medicine. At the time that was a six year post-graduate course, although our exams were at the end of the fifth year. It was quite nice, we had a kind of fake internship year working at the Repat Hospital which was fantastic. It was like being an unpaid intern, you got all the same responsibilities. It was a great opportunity to brush up on all the practical skills, like putting in drips, catheters, nasogastric tubes and things. Hence, by the time you were a proper intern working on wards, especially at night time, you felt really comfortable with all those sorts of practical procedures.

I then did a couple of years of general RMO jobs, and I was on what was called the family medicine program, which was a GP training program at the time. As part of that, I did a three month anaesthetics term which I really enjoyed. At that stage, I thought I was going to be a country GP, and had my eye on somewhere like Port Lincoln because of my diving and fishing interests. I decided that I'd go over to the UK to do the Diploma of Anaesthesia like many do before commencing rural general practice. I just really enjoyed the anaesthetics over in the UK. I had a mixed anaesthesia and ICU job over there for a year and then decided to apply for the training program back here, and was lucky enough to get a spot. I was back at the Queen Elizabeth Hospital for the first couple of years of that, then I went through the general rotations of basically all the different hospitals and ICU's, except for Modbury. I tried to do as much ICU as I could along the way. For my Senior Registrar year I actually went to New Zealand for 12 months in a little town a couple of hours north of Auckland where I did equal ICU and anaesthetics again. That's where I did a bit more retrieval work - I'd done some retrievals out of the Royal Adelaide and the Womens' and Childrens' Hospitals as a registrar which I'd enjoyed, and there was a bit of helicopter work up in the North of New Zealand for me as well which was good fun.

After that year I came back and started in private practice in Adelaide as an anaesthetist in 1998, and also worked at the Queen Elizabeth Hospital as a visiting specialist in anaesthesia, just one day a week. I carried on like that for a few years. When I got a bit bored, I thought I'd try something a bit different, so I applied for a job at Royal Adelaide, involving diving and hyperbaric medicine, which was obviously another interest that I had tucked away. I did that on and off for about 12 years, working either one day a week or one day a fortnight. In the middle of all that I went to Vanuatu for two years in 2004, again just looking for a change and a bit of an adventure. I'd been a consultant for about 6 years at that stage, and again I was getting a bit restless, so I dragged my whole family out to Vanuatu for a two year Oz Aid job as an anaesthetist.

Those two years were really life changing - I don't know if you've been to Vanuatu, but it's a really perfect mix of third world medicine with nice cafes and restaurants. So in Port Vila itself there are a lot of nice hotels and restaurants. But as soon as you get outside of Port Vila, and certainly when you move to different islands, it's back to basics. It was a spectacular experience. Lots of very basic anaesthesia for really complex stuff, from neonates through to whatever. Lots of ketamine anaesthesia with minimal monitoring, and it was back to the old drugs that I'd started with, such as halothane. I thought that that was just the best thing that we have ever done - it was a great family experience. As a social experience, it was also awesome. There was plenty of expats, and we were in a small community, so we made many close friendships. I did lots of ocean swimming and diving and all sorts of other activities there. The experience also allowed me to further my interest in cave exploration. There were lots of unexplored caves on those islands, so I was always off poking into new caves and mapping stuff and finding things for myself.

I came back from Vanuatu at the end of 2005-2006 and felt a bit displaced. After such an amazing experience, being back in my private practice and doing a little bit of diving and hyperbaric medicine left me slightly disgruntled for the first year or so. When you see the wastage in modern Western

medicine, compared to the problems of a resource poor country like Vanuatu, it's frustrating. I remember coming back and seeing one of the orthopaedic surgeons I was working with do a toe arthroscopy. I was just thinking "What the hell are we doing in this country, wasting money on crap like this?" That amount of money could do so much good in the world. I really struggled with that, and was a bit put out by the whole system. I eventually settled back down, and after a while, I started to get a bit restless again. I was about to reapply for my hyperbaric job when I opened the computer and there on the SA Health front page was "MedSTAR Employing Now". I knew Andrew Pearce, who was the Director of Education and Training there at that stage, so I gave him a ring and asked if there were any jobs going for a fellow like myself. That was in 2012, only 3 years after MedSTAR started. I hadn't really kept up with the changes in retrieval practices in South Australia since I was a registrar. I got a job with MedSTAR as a consultant and that was lucky timing because now it is so competitive to get a job with them. Through MedSTAR, I got involved with things like USAR - the Urban Search and Rescue - and Oz-MAT - the Australian Medical Assistance Team. I also did some work with the STAR Force on survival medicine, it was all just work that seemed compatible with my interests in the outdoors, exploration and caving etc. I had a good relationship with the Water Operations Unit already, who were STAR group of divers. I found lots of little niche interests that took my fancy, and here I am today. Now I work half-time for MedSTAR, and half-time in anaesthesia, privately.

What would you say would be the biggest challenges surrounding retrieval, pre-hospital and remote medicine, on both an individual and country-wide resource level?

When working in retrieval and pre-hospital care, you are faced with all sorts of mayhem with fairly limited numbers of people and only the equipment you have brought with you. I actually really also enjoy that aspect of it, you know - "What the hell am I going to do with this complex problem, I've only got a box of bandaids and an oral airway!". So it's that question of "How can I make the best of this situation with the limited equipment and people that I've got around me?" I find that really exciting and interesting, and that's what I like about remote area medicine full stop. I guess that's what I find as the biggest challenge at the same time. For me, as a doctor, going to roadside cases that paramedics take for granted - it's their everyday stuff - is a challenging environment to work in. A car accident scene or an industrial scene or even in people's homes, is not our familiar place. I guess I still find parts challenging: "Where am I supposed to be standing?" and "Who am I supposed to be talking to?", "Who's in charge here?" I know it comes naturally to some people after a few years on the road, but for us, it's still not frequent enough to be completely comfortable, I really enjoy learning from my SOT (Special Operations Team) colleagues, or some of the really experienced nurses here at MedSTAR who have done enough of that work to really be comfortable in that environment.

To add to that, what do you think are the challenges in these environments on a national or global level?

Certainly on a state or national level, the problem is that we are becoming the net service for country health in a way, because of their resource challenges. So many times you get called to a country hospital who has a locum working there for just a few days, who just doesn't understand all the systems, the people, the resources and the staff at that hospital. Whereas, if you have a GP who's been there for 20 years, that really knows the system and all the patients and their families really intimately, it's far less likely that they would need your assistance. A lot of those patients don't actually want to go anywhere for treatment either, they just want to be looked after as best they can, and they're happy to stay in their little country hospital. I guess, sometimes, the GPs and the nursing staff can't cope with it all. The patients lose the continuity that the older and more regular staff that have been there forever can provide - whether nursing or medical. Hence, we are doing more and more jobs for lower acuity patients. We are being asked to move these patients across the state and across the country, and we just don't have the resources to do it. It's also expensive, and it's not without risk either: putting our staff in a helicopter over the sea at night to go to the Yorke Peninsula etc. That's just a frustrating reality for all of us in the emergency services I suppose.

Do you approach your rescue and retrieval work with a bit of a different mindset to your clinic work?

Yes, I do. When I'm in the operating theatre, everything is so familiar, and so well controlled, that I wouldn't say I'm slack, but my checklist is easy. I glance at the machine for a quick check, and I know that it is all there. I have got a dedicated anaesthetic nurse who is there to assist and make sure everything is working well. Whilst I'm still careful with my preparation, you don't have to be quite as obsessive as you do in a retrieval setting where, if you walk out the door with a pump that hasn't been checked properly, or without necessary equipment, it could cost someone their life. It is the same thing when it comes to intubating someone. We have our RSI checklist, that we are obsessive about going through. I could tell you with my eyes closed everything that is on the checklist, and what I need to intubate the patient, because I do it every day in the operating theatre. However, in that very critical setting, for that very sick patient, you cannot afford to forget the sucker, or the syringe to inflate the cuff. Something

that small and simple is easy to grab in the operating theatre, but you cannot afford to not have it there. I think I am a lot more cautious and obsessive when I'm doing retrievals than I would be within the operating theatre.

Your work in Thailand last year was very inspiring, and I don't think we've seen much coverage of things like this in the past. Do you think the work there changed the public's idea or awareness of retrieval medicine?

I don't know whether people read about Dr Harris in Thailand, and thought of me as an anaesthetist or a retrievalist. I suspect they may think of me as an anaesthetist, because that's what the press has mostly referred to me as. I know within SAAS and MedSTAR, I'm known for working at MedSTAR, but I suppose most people think of me as an anaesthetist. I don't know whether it's had an impact on retrieval medicine per se, although it's been nice receiving all the nice messages I've had from ambulance and retrieval people from around the world. I think the anaesthetists are the ones that are especially proud because the anaesthetists are the fairly quiet achievers in the background of the theatre. They're obviously critically important, but they're not the ones who bask in the glory of the success of a surgery. The surgeons are the ones who get the patients initially, and the surgeon is obviously important. The nursing staff, anaesthetists, and everyone else in the operating theatre are equally critical, but the patient remembers the surgeon above and beyond everyone else, because they're the ones they've seen in their rooms beforehand, they're the ones they'll see on the wards afterwards, and so on. Anaesthetists have to be the sort of people, I think, who are happy in themselves and the job that they are doing, because they're not going to get many pats on the back from people around. I think that the anaesthetists are happy with me at the moment, to find someone who has done something a bit more surgical, in a way that a surgeon might get recognised.

What kind of planning and work was involved prior to actually carrying out the rescue?

It actually goes back quite a long way for me. I have been cave diving since about the mid eighties. In about 2008, I started to think about cave rescue of people through the water. Across the Nullarbor Plains, there's a cave called Cocklebiddy Cave named after a little town out there. It is about 6km long, underground, underwater. The cave has 2 rock air chambers in it, one about a kilometer, and the other about two and a half kilometers in. When you walk around in the second chamber and you're three or four km's underground, you think, "If I fall over and break my femur here, who is going to come and get me?" It's more like, "*How* is someone going to come and get me?" There is about 3km of diving to do to get to the place, and that sort of started to worry me a bit. I thought we should start practicing getting an injured person out through the water. So I set up a training group.

Unfortunately, most cave diving rescues are not rescues, they are body recovery operations. I got a few people over from the States who were experienced in that, and got the SA Police divers involved, and started to do some training with these people. I built my own course around it, eventually. Whilst that was all going on, we ended up going to a few body recoveries down at Mt Gambier, which was not pleasant, but it was actually quite good training for this sort of work. I was running an annual Sump Rescue & Recovery Orientation Program (SROP) down in Mt Gambier for cave diving, and started to build up some experience to see what works, what doesn't, etc. Questions arose during this time, such as, "Do you need a stretcher underwater for a patient who is injured, or are they better off just floating?" "What do you do for a spinal injury?" "What do you do for a facial injury?" We gave it a lot of thought. I set up an online group as well, called the Sump Rescue Group, with lots of people from around the world. We gathered lots of opinions through the chats between Sump rescuers around the world in this tiny, weird, online community. That was good mental and physical training for Thailand. Whilst we had never actually rescued anyone, we had certainly given it quite a lot of thought. The big difference was that these people weren't cave divers, they weren't even Australian, they were non English-speaking Thai children, and that was a major curveball for the whole rescue. Immediately beforehand, there wasn't a great deal that we could really plan, until I had gone over there, dived through the caves to see the shape and typography myself, and see the children. Then I could give it a bit more practical thought as to how we might go about it. The British divers who were there already had given it enormous thought and had actually come up with a plan of sorts, which I modified a bit, and then worked out how I was going to do the sedation part of it.

So leading on from that, what other resources were required for this kind of operation?

There were upwards of ten thousand people involved in the end. People all over the mountains trying to find new entrances, people trying to pump water out of the cave and drilling holes through the mountain into the cave. There were lots of military and police divers, and then the group of volunteer cave divers from around the world like myself. There were about 13 or 14 of us who did most of the diving past the first half of the cave. Lots of field medical resources were present to receive the kids when they finally did come out. There were two field hospitals there and first aid stations at different parts near the entrance of the cave. It was very resource intensive. Passing a stretcher, for example, was done along a line of people for 500 metres out of the cave, from the last diving point. So, there were hundreds of people involved in that one part alone. It was like a caterpillar that scooted the kids out of the cave. It's easier if you have unlimited people at your fingertips.

What have you taken from this experience to help you in the future?

Well, it's been good for my confidence, in that, something that I thought was impossible was achieved. I didn't think that anaesthesia on a child, and then immersing them for a couple of kilometres through a cave would be possible. I thought it was destined to fail, so I actually went into it with

grave reservations. I guess my feeling is the reason that it worked was primarily because of the quality of the team that was assembled. This group of a dozen or so international cave divers were just an exceptional group of extraordinarily pragmatic and courageous people. Nothing phased them really, well not externally anyway. Personally, I was terrified. Everyone just decided that this was the only possible chance these kids had of surviving, and even though it was a million to one shot, we all decided that we were prepared to commit to the plan. Once that decision was made, everyone went along without hesitation. I was very proud to be a part of this group of people who were just extraordinary. The ability of team work - high quality teamwork - to overcome insurmountable obstacles, would be the big lesson for me.

Do you think that this area of rescue, or cave diving safety, is something that needs more focus and education?

No, I don't think so. Cave diving training is already extraordinarily thorough, and safety is a huge part of the training message. It is such a minority sport that the chance of another cave rescue involving a flooded section of cave is, sadly for my rescue program, very slim. As much as I would like to be doing it a bit more often with a good outcome, I think that it is actually exceptionally unlikely. We went to a big "Lessons Learnt" meeting in Canberra with the AFP and various other emergency services representatives from around the country. Whilst they are in agreement that another cave rescue was probably unlikely, what it did highlight was the need to think of unusual rescues. Is there like an "All Hazards Approach" that we learn for the bizarre and unusual? For example, if 'Rescue X' is required that you can't even imagine at this point, how do we get the three or four experts in the world into Australia to facilitate it, and what if one of them was a doctor and you needed to get medical registration for them in six hours? The meeting outcomes suggested that we probably couldn't achieve the above, because we're so buried in bureaucracy in this country. These sorts of things are relatively insurmountable. So we went away thinking about how we might overcome some of those issues. Who can guess what sort of weird problem might arise where we would need three strange women from Mongolia who are the only people in the world with this capability. How would we cope, like Thailand did, with bringing in all these foreigners. I think the Thais did a really good job in that regard.

Where would you like to take this work in the future?

This year is going to be a bit busy for me. After receiving the Australian of the Year Award, I'm actually taking a bit of leave without pay from MedSTAR from April onwards. I will continue to work in private practice, and go to lots of conferences. I am quite keen to talk to a lot of emergency services around the world about the lessons gathered from the rescue in Thailand. I've been invited to a few interesting meetings along those lines. It's funny how your life takes a sudden right-hand turn and you're off doing something different, but there's lots of opportunities for me, and as you may have sensed by now, I get a bit bored doing the same thing. I'm quite keen to see where this takes me and what things might arise from it, so I'm kind of open minded about it all.

Final question, is there any advice you'd give to a medical student, like myself, who might be interested in a career in retrieval medicine in the future?

The best pathway into retrieval is either emergency medicine, anaesthesia or intensive care. It basically has to be one of the critical care specialties because of the type of work required. Do a critical care elective as a medical student, if you're interested, because everything you've got on your CV from this point onwards counts. It is a rather sought-after position because it sounds exciting and attractive, and like any job, it has got its bad and good moments. It is reasonably competitive, so it is worth deciding from the outset whether that is what you want to do. Being a paramedic, for example, is an awesome starting point, because you already know the system and understand the emergency services. In the last couple of years of your degree, start thinking about which of those three critical care specialties take your fancy. Start letting people know that you are interested in that specialty, along with a career in retrieval medicine. Just make it known. Come sit in on the audits and CPD's we have at the retrieval base. Show your face around. We've certainly had registrars like that who have made it clear that this is where they want to end up, and you keep seeing their face around all the time. The more often we see them, the more often we think, we should give them a ring next time we're employing. You've just gotta be a serial pest - that's the best way to do it!

AVERAGE REFLECTIONS ON THE AVERAGE HEALTH OF AVERAGE PEOPLE

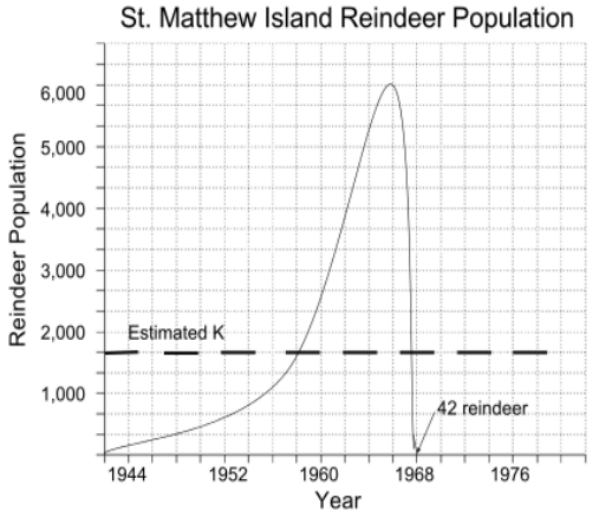
PROFESSOR EMERITUS JOHN WILLOUGHBY

Hon. Consultant Neurologist FMC, Doctors for the Environment Australia

I am writing this in the concluding years of a career in neurology and neuroscience. I am concerned for humanity. What do I conclude about the human condition at this time? In a nutshell: we are what we are: overbreeding mammals headed for a population crash as we over-consume the world we live in.

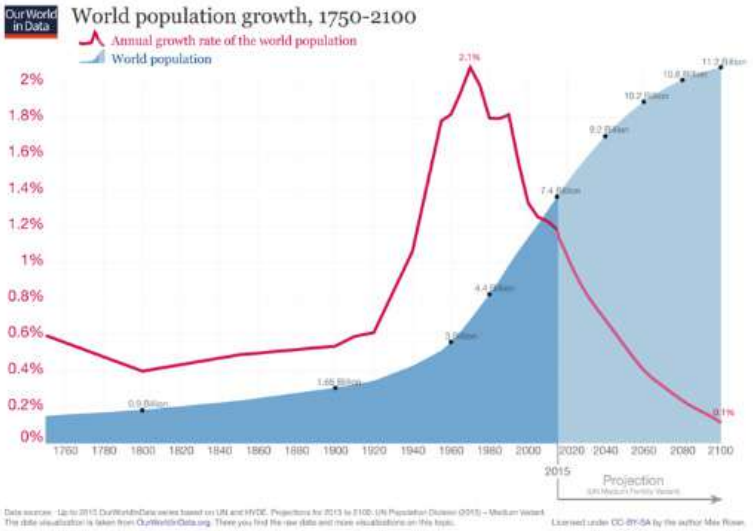
The plot on the right shows an actual population crash (CC BY-SA 4.0). It is deer numbers over 22 years, between the founding of a deer colony on an island, until its near demise(1). Multiple factors led to distressing deaths in distressing numbers: too many deer, too little available forage, poor prior health due to inadequate nutrition and, finally, a burst of freezing weather.

Models of population crashes exist for many species: bacteria, algae, fish (think Mendindie Lakes) and mammals (besides deer, think rabbits).



What about humans?

Here is a plot of the human population on our 'island earth', taken from Max Roser and Esteban Ortiz-Ospina (2019) - "World Population Growth".(2) Published online at OurWorldInData.org. Retrieved from: 'https://ourworldindata.org/world-population-growth' [Online Resource]:



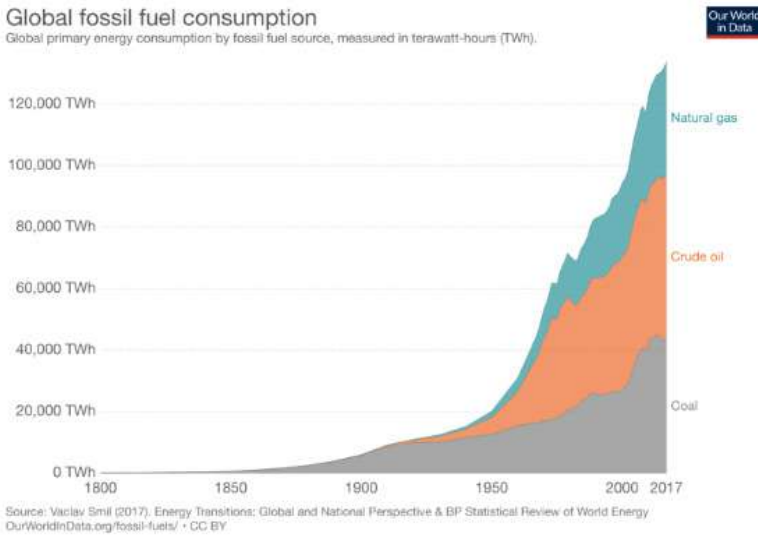
Two factors explain the rapidly growing human population: i) humans beget little humans (geometric growth) and ii) survival through reproductive years is now usual, where-as it used to be unusual.

Given the rising population, we are motivated to ask "... and what happens next?". One answer has to be "something like what happened to St Matthew Island deer". Without more food and, even with less begetting, this graph indicates the likelihood of a population crash. Deaths will be due to starvation and its consequences, ill-health (infectious disease) and social discord (war). Now, an additional factor which exacerbates all of the above is climate change.

It's obvious why we beget children – it's what we do, otherwise, there would be none of us.

What we also do, for ourselves and for our children, is utilise resources. Essentially, by using and acquiring resources, we increase our own security and improve the prospects of having and protecting our children.

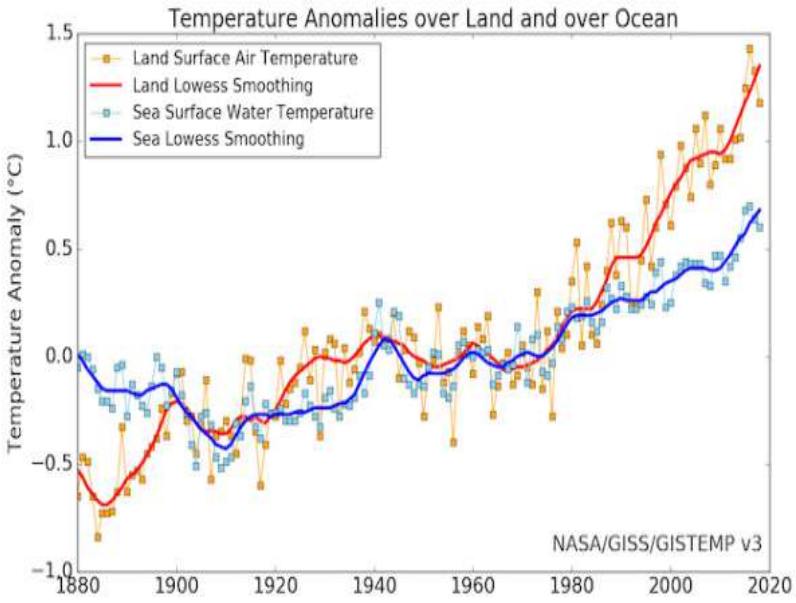
Here (below right) for example, is our use of one resource, fossil-fuels, over the last 150 years(3). It corresponds to the population increase over the same period and is, presumably, driven by it.



We exist because our own human ancestors were successful in controlling their resources and reproducing. Children mark success in the chain of life. The stronger our male ancestors were, the more resources they controlled, the more partners they had, and the more their children contributed to the

chain of life of which we are a part. Evolution has always favoured those who left the most offspring: his fact defines evolution. Putting it bluntly, those more exploitative of the Earth's resources and of child-bearing partners, helped make a contribution to the kinds of people we are right now. This explains a lot, for example: the widespread subjugation of women. We are the outcome of hundreds of thousands of years of winners controlling more resources and having more children. Those who didn't successfully compete didn't leave children to contribute to whom we are. We go into our lives by carrying the genetics of the winners and behave in the same way by acquiring resources and reproducing. This is what humans have always done and that's what we always will do.

Acquiring Resources



In the competition for resources, two very different strategies suggest themselves: cooperate with a group of people, albeit, then having to share the gains, or, go at it alone and keep everything. It seems to me that in these strategies, we see the beginnings of approaches to life categorised today as either 'left-wing' and 'right-wing'. Other terms for left wing are: 'socialist', 'pluralist', 'egalitarian', 'progressive'; other terms for right-wing are: 'individualist', 'anti-pluralist', 'self-sufficient', 'conservative'. I'll use 'left-wing' and 'right-wing' for simplicity. I'm not going to address the horrible extremes in left - or right - wing behaviours and attitudes. People in left-wing communities (have to) share, (have to) assist others, (have to) think of the impacts of their behaviour on others and (have to) cooperate. People in right-wing competitive communities (have to) do what they can for themselves, (have to) compete, (have to) take responsibility for themselves and (have to) reject restrictions imposed by others on their behaviour.

What has distressed me in observing humans these days, is the different kind of influence left-wing and right-wing attitudes have had on the trajectory of humanity. Just look at global warming(4). We have people, often right-wing, who spend time arguing with thermometers! (denialists) and there are people, often left-wing (environmentalists), deeply concerned.

Here comes the neuroscience

By measuring physiological markers of emotion and by using functional brain imaging (with EEG and MRI), studies have revealed remarkable average differences in activation patterns of people holding average left-wing or right-wing attitudes. I emphasise 'average' here: we all vary uniquely and, consistent with uniqueness, people's attitudes on issues are not reliably predictable. Brain imaging is characterised by surprises and variation, however, on average, there are clear trends.

Here's a taste. In a typical study(5), people are scored on a left-wing to right-wing scale using answers to questions like "Do you support same-sex marriage?" "Do you support gun control?" "Are you religious?" etc. Then the participants undertake an apparently mindless task in which they have to respond to a visual signal (briefly displayed on a monitor) by pressing a timer-button. They are given these instructions: "Look at the monitor. If you see "X" appear on the screen: **hit** the button. If you see "Y" appear on the screen, **don't hit** the button", all the while their brain activity is being recorded. In this test, "X" is very frequent, so the usual response to a letter appearing is to hit the button. When the very rare "Y" appears, the response is to withhold the usual action of hitting the button. [These kinds of tests are known as "Go, No-Go" tests.] The results are clear: people who score as right-wing have less activation in regions do to with change-detection during the No-Go trials, than people who score as left-wing. You would be thinking: "responding to "X" and not responding to "Y" is NOT a political matter". So, what are they thinking? Well, there are many studies demonstrating that people on the right of the political spectrum have stronger markers of emotional activation to unexpected change than people on the left. Given this, my interpretation is: while people on the right might respond less to the actual evidence that things have changed, they get more emotional (angry?) instead - a hypothesis that, as far as I can tell, remains to be tested!

Here, from a review of the field of political neuroscience(6), is another kind of difference: people with left-wing attitudes have a larger anterior cingulate cortex, smaller (R) amygdala and smaller (L) insula(7). These findings correlate with levels of activity in these structures when dealing with information counter to a person's experience. The interpretation here is that people with left-wing attitudes think more deeply when information is unexpected (anterior cingulate cortex), in contrast to people with right-wing attitudes whose responses are more emotional (amygdala, insula). So, there are interesting, different, brain networks activated in people having different political attitudes. Another study, unfortunately for all of us, left - or right - wing, shows differential activations within medial prefrontal cortex and amygdala in response to positive or negative information about our preferred or non-preferred political candidates(8) – a result emphasising the actuality of fixed political bias.

Feeding my own prejudices, Jost and colleagues(6) summarise that death-anxiety, fear of threat or loss, intolerance of

ambiguity, etc., were all associated with people having right-wing attitudes. Being open to new experiences, complexity, tolerance of uncertainty, and self-esteem were all features associated with people with left-wing attitudes. And this is from other authors: "ideology is not a superficial label or bundle of topical positions but rather is a central component of an individual's general life orientations"(9).
My spin on all this: humans are humans; they do what they do; nothing will change most people: they are set up to be the way they are. The worriers should just give up…maybe.

What might we do?

This is a hard question: what can one do, oneself, in this threatening situation? The situation humanity finds itself in is like being in a bus in which a democratically-made decision has been made that we should drive the bus off a cliff. My answer is: one might as well go along for the ride because, although conflict might enable the rationalists to stop the bus, the act of having to resort to violence simply sews the seeds for a more violent future. I think an answer to what we might do, therefore, is do things that matter to us while hoping for the best.

Things that matter to us

Medicine

Our experience is that we have to deal with medical problems. Particularly, we see ageing of the population with the increased emergence of age-associated disorders, cancers, organ failure and more. Concurrently, society and our hospitals are pressed to cope with the striking increase in these disorders. Health care is becoming increasingly difficult and costly. Did we know this would happen? Of-course! Demographers and statisticians made it plain years ago. What did we do? Nothing but more of the same as before: minor changes here and there. What should we do? Re-design health, and as individual medical practitioners, we need to cooperate with the changes as best we can. This is a fraught issue because if medical care is to be sustainably-provided, it can't be done in hospitals and it cannot be unlimited.

Environment and Resources

It is also a reality that we are consuming our environment and its resources (which equally mean our health). At every level I can think of, links-of-impact join our place in the world with the rest of biology.
We are all used to the idea of parasites, bacteria, fungi or viruses invading our intra-personal space – the fact of infection is enough for us to realise the significance of one of the links. Alternatively, our colons are full of bacteria that greatly benefit our health.
We take it for granted that animals interact with our lives – we are variously wary of them, fear them, love them, eat them, bet on them, play with them or watch and enjoy them. We may also need to be reminded that a relationship with an animal prolongs our lives. Spiders, flies, ants, grubs, bees, we tend to avoid, but their beneficial impact on our lives is immeasurable – fertilisation of flowers of vegetables, or the cleansing function of these animals on decaying matter.
Plants are stunningly interconnected with us. They provide our oxygen. Some we plant and harvest to eat or wear, some we plant just to admire, some we harvest for their beautiful timber, using the heart of the plant for constructing our houses or using in furniture. Other plants shield our homes from the wind or sun, or cool our urban environment or cleanse our air.
What should we as doctors do? My spin: motivate for environmental protection at all levels, everywhere, and motivate for re-use of resources, and re-use of re-used resources – the so-called 'circular economy': nothing is to be discarded.

Population

Because it relates to what I'm going to say next, it is necessary, here, to re-state that global population is a problem. Fortunately, birth rates are declining, almost entirely due to improved education of women, which, we hope, will continue. However, we're still heading for a high maximum and we can't cull humans. We'll be culled by forces of nature.

While hoping for the best

If you have offspring, I think a good plan is to live ethically, minimise your use of resources, be collegiate with fellow humans, promote workable solutions to issues when you find them, educate others and be educated by others, hope that things will change, but let go of expecting that things will change.
If you don't have off-spring, besides living ethically and, in the spirit of population reduction, I think a perfect plan is don't have children. In the happy state of begetting no children, you can let your little twig of evolution die out – with no worries!

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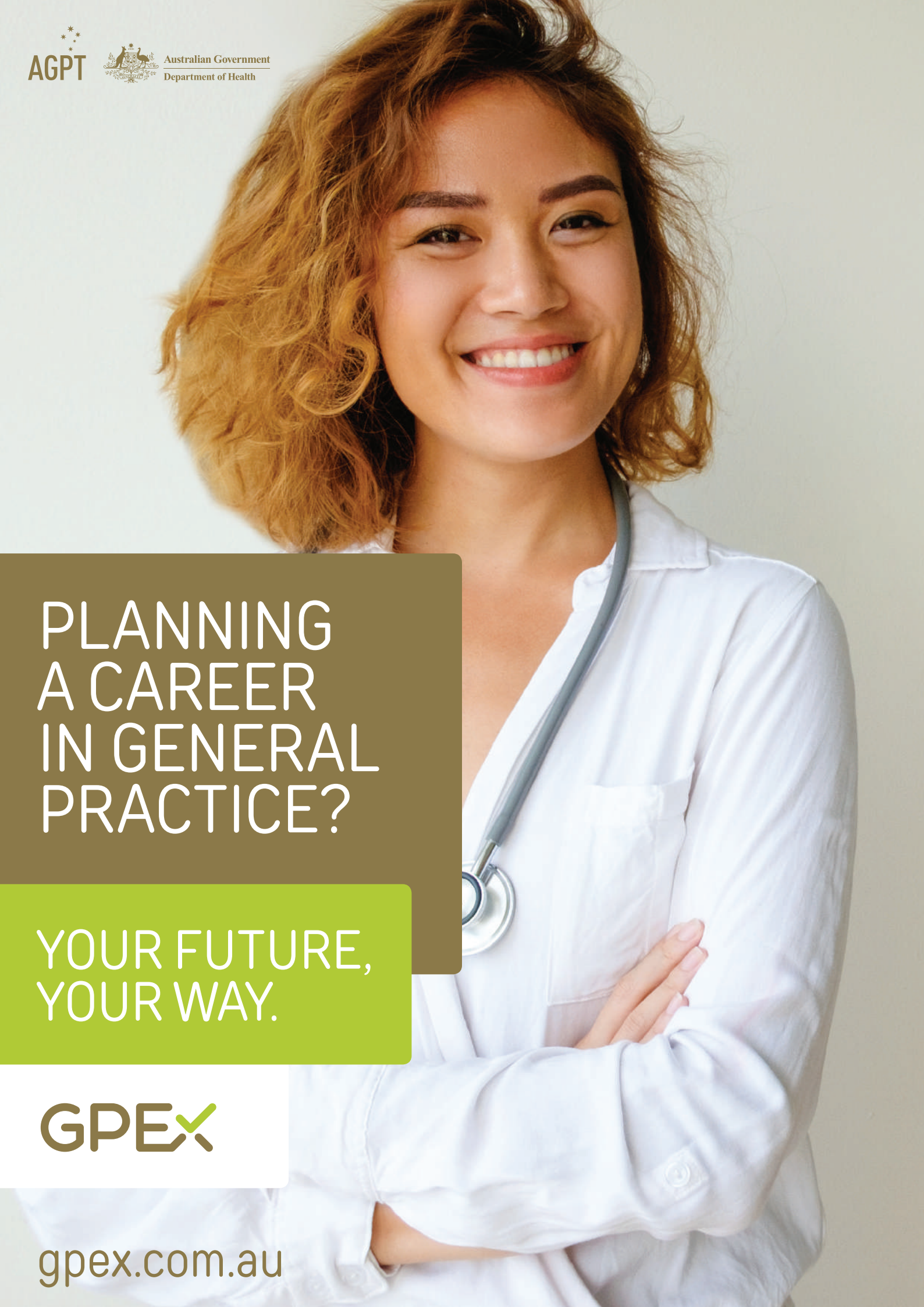

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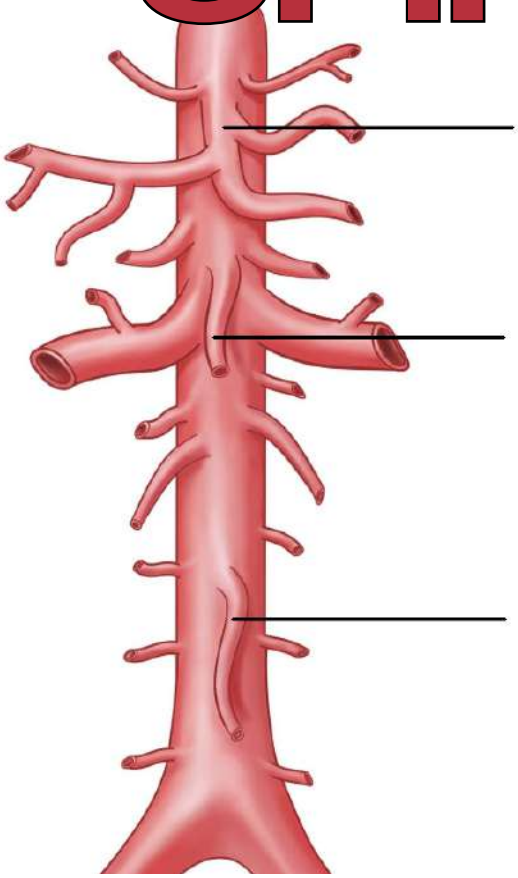


MOUNTAIN MADNESS: A FORAY INTO CEREBRAL OEDEMA

JAKE PLANE

MD2

Altitude sickness. It can strike fear into the heart of even the most seasoned mountaineer. In stark contrast to nearly all other conditions that can kill you, there are almost no reliable indicators to determine ones risk of developing symptoms. But if you ignore the statistics and use the same cognitive processes smokers use (ie "It won't happen to me…"), you can quite easily be convinced to book a trip to Tanzania, with the intent of summiting Mount Kilimanjaro. Mount Kilimanjaro towers like a behemoth over the Serengeti. At a whopping 5895m above sea level, it is no surprise that this is one of the 7 peaks of the world.

I must admit that when I first saw the mountain towering above me, I felt the same trepidation I felt when starting medicine as a first year! Nevertheless we persisted, and having climbed Mount Lofty several times to improve our cardiovascular fitness - Nick and I felt prepared for what lay ahead. Initially, it seemed we were right and had prepared well. The first day came and went without incident. Quickly, the second day of the trek came and went, again without too much struggle. Slowly but surely we were making our way ever closer to the summit.

Day 3 saw us ascend to lava tower- at an elevation of 4630m it would be the highest point we would reach before the summit night. Most of the trip to lava tower was fine, but on the final approach I began to struggle, I was short of breath, and began to feel a strong global headache. Every step felt as though I was running a marathon at a sprinting pace. With the encouragement of our guides, I made it to lava tower earning a much-needed rest. As lunch was served, to my surprise I was not even remotely hungry- strange for someone who is almost always hungry! My first mouthful of food triggered such intense waves of nausea that I began to sweat profusely. Fortunately we soon headed for the nights camp, and the drop in altitude made me feel like a new man, and after nightfall, I slept soundly.

Much like the foreshadowing in a thriller novel, my experience on day 3 prophesied what lay ahead. For each day, by the end of the day I would feel short of breath and experience the same global, throbbing headache. Each subsequent morning, my symptoms would be resolved, but each day my Sp02 would fall a few precent.

At long last it was summit night and with a mere 4 hours of rest, we awoke an hour before midnight to start what would be a whopping 19 hours of hiking! After what seemed like and eternity of trudging through the falling snow, dawn broke- revealing the summit in all it's stunning glory… Unfortunately still hours away! One foot in front of the other saw me reach the top, though the extreme shortness of breath saw me take half an hour to complete the last 30m to the top. The exhilaration of having finally made it, was enough to keep the persistent headache from my mind, and after a few happy snaps, we returned to basecamp (4600m elevation). Back at basecamp, the exhilaration began to wane, and in it's place I found a monstrous headache, bringing back visions of the morning after too many tequilas. Again, my appetite was gone, and after struggling to eat some food, I began to stumble off to take a nap. At this point I noticed for the first time that my vision was beginning to blur, to such an extent that I could no longer read. My movements were clumsy and ataxic, and my words slurred. I was not the only one suffering. One of our climbing team, a Canadian Firefighter, had stumbled and collapsed on the way down, stating "Ill just rest here in the snow and catch up with you guys later". An emergency team meeting was quickly arranged. It was decided that we should descend as low as possible, and should my symptoms worsen, I would be evacuated by helicopter. I headed back to the tent to pack my bag, as I entered the tent I was overcome by an intense tiredness, and promptly lost consciousness. I passed out a further two times before I managed to finish packing my bag.

Descending a mere 200m saw my symptoms disappear completely, and as the sight of a rescue helicopter flew overhead, I understood just how this mountain claims and average of 8 lives every year. Yet, both Nick and I survived to tell the tale of an epic adventure that is surely worthy of a Mahara post.

GLOBAL HEALTH FORUM ONE

DAN RING

MD4, HHRG Co-President

Over the course of a weekend, a team of Flinders students bravely ventured into the depths of Adelaide Uni to attend the first AMSA Global Health Forum of the year. There, they met with representatives from across the nation to talk about the big issues in global health, how to impact them and how to keep your own societies sustainable for the future.

You might be wondering, what is global health? How can the health issues of 7 billion people be condensed into a 2 day forum? The short answer is it can't but global health in general aims to look at the issues affecting the human population at a macroscopic lecture. Think public health but the fate of the planet is at hand.

Obviously, climate change was high on the agenda. It was noted that our government in particular was not doing enough to meet the requirements of the Paris agreement. The latest data combined with everyone's experience of Adelaide's 46.1°C 'hottest day on record' proves that climate change is well on its way. Even with very ambitious emission reduction schemes in place, this world is still going to be heating up by a few degrees leading to a fixed pattern of chaotic weather systems in the future. More needs to be done.

The humanitarian crisis which is Australia's offshore refugee camps were also brought up. This is a sphere where doctors in particular can enact change. Dr Keren Phelps, a current MP spearheaded the medical evacuation bill successfully through parliament, demonstrating the importance for us as medical people to advocate for our patients who cannot.

Highlights of the forum included making our own lunch together proving sustainability is fun and cost-effective! We also heard from guest speakers on the experiences of refugee people in the Australian health system and the growing prevalence of 'chemsex' in the wider community.

Also, preferential voting is a thing in Australia meaning you can and should vote for the little guy.

A big shout out to all the Flinders delegation for engaging in the process. It's great to see how active everyone is in the issues beyond studying for the PT. Looking forward to forum two!

SPOTLIGHT ON: KRITIKA MISHRA, MD1 REP

INTERVIEW BY SAI LEKSCHMI CHANDRAMOHAN

Where is home for you, and what was your work/study background before medicine?

I was born in Delhi, India, and moved to Adelaide with my family when I was nine months old. Adelaide is, and always has been, home to me. I graduated from school in 2016, and enrolled into the Bachelor of Clinical Science and Doctor of Medicine in 2017.

Do you have any interests/ hobbies/favourite activities outside of Medicine? If so, what are they? How did you first get involved in these?

Outside of university, I work as a tutor. It is incredibly rewarding to follow the journey of my students, most of whom are striving to become doctors. I understand that the journey of getting into medicine is tremendous, and I am passionate about supporting students to fulfil their potentials and short and long-term ambitions. Along with this, I enjoy public speaking, sports, dancing, playing the piano and crafting – activities which I have been involved in since my schooling years.

What inspired you to take on the role of MD1 Student Representative?

The amazing work done by the FMSS committee which facilitated our cohort's transition into MD – which can be nerve-wracking and at times overwhelming – coupled with my passion for communication and leadership inspired me to apply for this position. I am incredibly grateful to be representing such a supportive, kind and welcoming cohort. As the MD1 student representative, I strive to make our university journey a platform for not only academic success, but cohesion, open-mindedness and development.

What is your favourite book?

My favourite book is A Thousand Splendid Suns by Khaled Hosseini. Set in the volatile atmosphere of Afghanistan in the 1960s, this is a breathtaking tale about the journey of two victimised women who, with startling heroism, overcame the atrocities of their abusive marriage during the oppressive rule of the Taliban.

When you were ten, what did you dream of one day becoming?

I wanted to be a performer – I loved acting, singing and dancing!

What did you expect med school to be like, and has your experience reflected your expectations?

I expected med school to be busy and rewarding, and it certainly has been the same. Whilst we are always busy finishing assignments, studying for weekly iRATs and simultaneously managing commitments outside of university, med school has been enjoyable in many ways. Our year level is like family, and there is immense warmth in the support and friendship we foster. Additionally, from talking to patients on the wards to learning about the social determinants of health and the fascinating science behind the human body – the journey so far has been rewarding and fulfilling.

What are your top 3 study tips?

Be organised! Always keep up-to-date with assessment due dates and prioritise study tasks on your to-do list.

Maintain the right balance rather than tiring yourself out studying all the time – the brain needs a break! Make time to do things you enjoy and are passionate about during the week, along with studying.

Always keep your goal in mind - this reiterates the true and rewarding applications of your study, reminding you about your passion for delivering patient-centred care.

How do you like to unwind after a long, stressful day at university?

Driving home with my favourite songs playing in the car, coming home to my family and a delicious home-made meal followed by a warm shower helps me unwind after a long day at uni.

Who inspires you, and why?

My grandfather was, is and always will be my biggest inspiration. He was not only an empathetic, professional and dedicated doctor, but a selfless, generous and caring person. His passion for his work, his love for his family and his ability to balance all facets of his life so neatly and effortlessly were certainly inspiration.

Have you done much traveling? Where would you like to travel in the future?

I have visited many places in Australia – Cairns being my favourite destination, and have travelled overseas to India. In the future, I would love to travel to Bali, New Zealand and Greece. I love adventure activities and wandering around in nature.

What's been your most favourite experience in medicine so far?

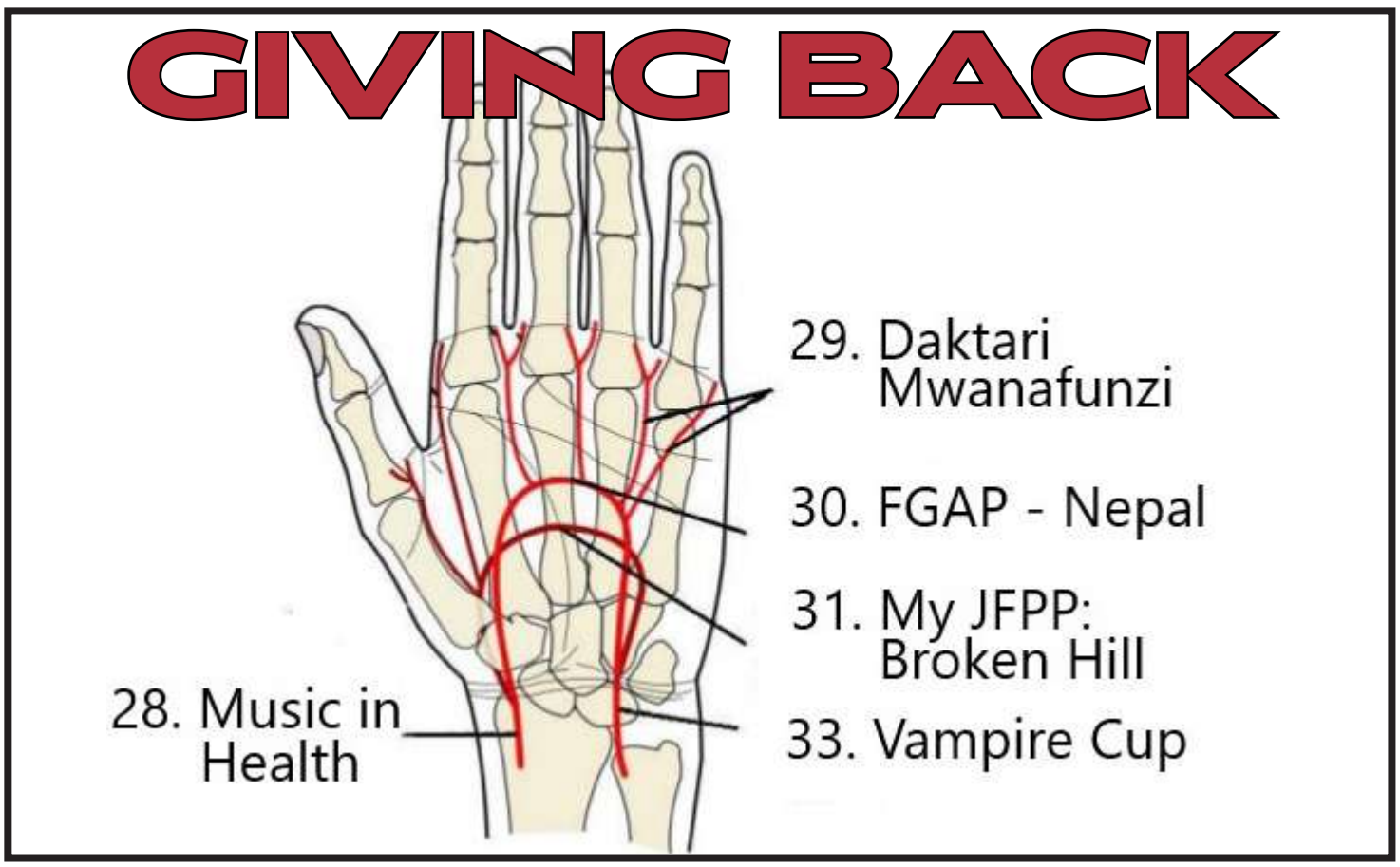
Talking to patients on the wards and listening to their stories has been unprecedently the most heart-warming and insightful experience in medicine so far. My interaction with patients motivates me to work harder so that in the future I can work with these patients to provide individualised care and help them in achieving their goals.

How do you think doing medicine will change you?

I believe studying medicine will make me a more empathetic and sensitive person. Doctors are most definitely devoted to and passionate about caring for others, and in doing so learn the art of communication to ensure that patients, often in vulnerable positions, feel respected. Hence, practising empathy and sensitivity will be instrumental in ensuring patient comfort.

What are you listening to right now?

Beyoncé , James Arthur, Daughtry, Coldplay and lots more!



MUSIC IN HEALTH

LIAM MCCLORY
MD2

This semester I was lucky enough to be involved in the Music for Health program along with a small group of my MD colleagues. Having a passion for music but not knowing too much about the program, I went in with an open mindset. What I didn't expect was for the program to have such a profound effect on my outlook on the use of music in medicine, including the realisation that music transcends self-interest as a valuable therapeutic treatment for others.

Outside of the practical learning, I was fortunate to have the opportunity with some other colleagues to take some acoustic songs to the wards and play for patients, visitors and staff. The reception we had was resoundingly positive from everyone. Our songs were met with laughing, crying, singing, clapping and giant smiles. Being able to share with people something that is close to my heart, and seeing the impact it made, was the best experience I have had so far in my medicine journey. If I made a difference to even just one person's stay in hospital that day, it was worth it. Breaking up the routinely sterile and dispiriting hospital environment with a little music is sometimes just what a patient needs – a complimentary form of therapy that can have profound effects on patient outcomes.

Music therapy has been shown to relieve stress and improve emotional or behavioural problems. It has been shown to help treat depression and anxiety, often being used to help elderly patients cope with memory loss associated with diseases such as Alzheimer's Disease and Dementia. It has also recently been shown to be of significant benefit to patients with aphasia, helping them learn to speak again after suffering a stroke. Additionally, studies have demonstrated that playing music as a medical student helps improves study outcomes, verbal memory recall and reduces stress.

I would like to extend my thanks to the Arts in Health faculty of FMC for allowing us to share our music, to the MD students involved and to Alice Orchard and Amy Wyatt for their hard work running the program.

DAKTARI MWANAFUNZI

NICK PETRAKIS

MD2

As we stumbled across the blistering tarmac in a jet-lagged haze, the stifling humidity hit us. Jake and I had just arrived in Tanzania, a mere 3 days after the 4th Progress test, ready to start our international medical adventure. As we filed into the crowded customs office, we were greeted by a big sign with the word 'EBOLA' in red across the top, with a series of caricature-like cartoons depicting various symptoms and blood-stained bodily functions. We were then ushered into a crowd where the ad hoc process of applying for a visa began. We quickly became accustomed to something the locals called 'Swahili Time'. Swahili Time is the embodiment of the laid-back culture of Tanzania. From appointment times to public transport, which is its own adventure in itself, things happen in Swahili Time, "Pole pole", slowly.

Arriving at our accommodation, we found ourselves situated in a compound nestled amongst embassies and a complex belonging to the Tanzania Intelligence and Security Service (their version of ASIO). The facilities were basic but adequate, with intermittent power and a lack of air-conditioning allowing us to acclimatise quicker, despite a difficult night's sleep.

The next day our local guide, Mo, showed us around the area, pointing out the best places to get everything from street food to a local liquor called Konyagi. Konyagi was viewed by some of the locals as an antimalarial, and cost about $3 AUD for 300ml (though, I have doubts about their research methods). As we walked around, we would receive stares from small children and here the chattered conversations of the word "Mzungu", meaning white person. Clearly, we stuck out like a sore thumb.

We jumped on a shanty bus as it slowed down to an achievable pace, never stopping, and in no time flat, we had arrived at the hospital. The layout of several buildings interconnected by open air corridors meant that it was not an unusual site to see patients in beds being wheeled from place to place from the road. Even the operating theatre was in a separate building and, due to the lack of air-conditioning, it was not unusual for operations to be performed with windows open.

Walking to the emergency department, we were directed to the resus rooms where we would spend the next few weeks. The 4 resus rooms were approximately 5m x 5m with two small windows at the back and an open front. Each room would be used to care for anything from 4 – 6 patients at a time, leaving very little room to maneuver. The room contained two monitors, with one always being the "good" one, and the other having little to no functionality at all. Resus trolleys were often empty and the oxygen supply was intermittent. It was not unusual to be hand ventilating an intubated patient and for you to lose the O2 supply. So began our crash course introduction to resource poor healthcare.

With a lack of resources and equipment, the clinicians valued a strong clinical skills base, and resourcefulness. Such skills became very useful when a patient presented to the ED with crushing left sided chest pain. An ECG was attempted and the machine, that usually showed a defective V4, was completely on the fritz and did not give any trace. Several attempts were made to rectify it but to no avail. Instead, the defibrillator, an old 1980's relic with Hollywood quality hand paddles and all, was grabbed and applied to the patient's chest. Success! We had a single lead trace. Now to repeat the process a further 11 times and compilate the results to form a 12 lead. Ingenuity at its best!

But sadly, there were some things that even the greatest level of ingenuity and resourcefulness could not fix. An 8 year old boy whose parents could not afford the oral antibiotics to treat his periorbital cellulitis, had developed a post ocular and cerebral abscess. A young mother with 3 years of abdominal pain, who could not afford to feed her kids and pay for the $150AUD CT upfront, had finally presented, only to be told she had uterine cancer that had metastasized throughout her body. And I can not tell you how many young men and women in their 40s, and even 30s, presented with significant cerebral bleeds due to untreated hypertension. Many of the patients we saw were likely to die, and soon.

A young local doctor confessed to me that he had considered going into obstetrics so that he could bring life into this world instead of constantly watching it leave, but he never did. My time working in Africa was not an easy one, but it is one I would recommend to anyone who wants to understand what medicine truly means.

"Wherever the art of medicine is loved, there is also a love of humanity" - Hippocrates

FGAP - NEPAL

NICK WAN
MD2

There were a total of 10 students that represented Flinders University at Kathmandu Model Hospital. We were broken up into pairs, and we were attached to different departments in the hospital. I spent my two weeks in Nepal under Dr. Udaya Koirala of the General Surgery department. The staff were extremely warm and patient with us; they often stopped to check if we had understood what the rationale of a certain treatment was, or if we could keep up with the medical team.

We spent our mornings doing rounds with the team, before helping the interns to check on any post-op patients. This included changing patients' wound dressings, as well as taking out foley catheters. After lunch, we would either be attached to a clinic or to the emergency department. One key difference that I saw as a student at Flinders vs. at Kathmandu Model Hospital, was that patients were awake and not given anaesthetics for routine colonoscopies.

Surgeries at the hospital took place in the second half of the day. It was an eye-opening experience. Due to the lack of resources in the hospital, some of the surgeons did things very differently compared to how they would do it here in Australia. Hygiene was not a factor that was placed very high on the priority list, due to limited resources. With only a limited number of sutures and threads available per patient, the needles were often re-used. Still, the lack of resources did not stop the department from performing a wide range of procedures. Cholecystectomies were common and we managed to observe a pancreaticoduodenectomy as well.

All in all, Nepal was an extremely humbling and enjoyable experience. I would recommend any juniors who are considering to join FGAP in 2019 to sign up, as we had all thoroughly enjoyed our time spent there.

MY JOHN FLYNN PLACEMENT - BROKEN HILL

JEMIMA STAUDE
MD2

When I first applied for JFPP, I imagined spending my time on a nice coastal town and visiting the beach in my down time. Ironically, I was placed roughly 600km from the nearest coastline and spent 10 of my 14 days of placement in over 45 degrees heat. Yet, since spending my first placement in Broken Hill, I wouldn't exchange it for all the coastal towns in the country (although this might be the long-term effects of heat stroke talking).

Unlike many of the JFPP sites, Broken Hill offers placements within their hospital, allowing you to choose from different wards/teams. I was limited with what I could choose from on my first placement, as there were other JFPP students there, as well as full time NSW medical students on their clinical placements. For that reason, I ended up doing 2 weeks on the surgical ward. This probably wouldn't have been my first choice, given that I was a first year. Also, despite spending a whole year in medical school, I still felt as though I knew nothing except that mitochondria are the powerhouse of the cell. Thus, when it came to my first day of placement, and I was trekking to the hospital through knee deep red dirt, getting dehydrated by the minute, I thought, 'fake it till you make it' was probably an apt motto to live by for the next few weeks. I was right about this, and my first placement in Broken Hill was AMAZING! I was fortunate enough to meet some phenomenal mentors in my two weeks who answered my copious (and annoying) questions, and even let me scrub in and assist on surgical procedures. Whilst it was amazing to hold a retractor, cut suture ties and show off my knowledge of the causes of post-operative infection (thanks Grey's Anatomy for that one), my placement (and probably all JFPP placements) gave me an excellent opportunity to work on the skills that I had already learnt, but in a non-assessed environment. I was able to talk to patients, help write up patient summaries, interpret lab results,

check wounds, monitor vitals, examine patients, and so much more. Sometimes, we get so caught up in learning the next block and doing the next iRAT, that we don't get the chance to develop our clinical skills, which is exactly what JFPP allows you to do.

Whilst it was excellent fun learning to scrub in on surgeries, go on ward rounds, and quickly google the contents of the spermatic cord when the consultant asked (for context we were about to head in for a vasectomy), my placement in Broken Hill reminded me of something very important about public and rural health. We are massively understaffed when it comes to rural doctors. The surgical team (and lots of other departments in the hospital) do not have permanent consultants, and therefore rely on locums from across the country working for 1-2 weeks then leaving. The same thing happens with the anaesthetist, O&G and the medical team (at least while I was there). In fact, for two of all the days that I was there, there was no surgeon at all. As a result, the surgical registrar could not work at all and every surgical patient had to be flown to Adelaide or similar places. Every patient that came in that looked slightly surgical had to be flown out, costing thousands of dollars each time. Seems like a pretty rough deal for communities like Broken Hill and countless others in our country. It really opened my eyes up to the importance of not only rural GPs in the management of patients, but the rural Hospitals too. Just some food for thought!

Another great aspect of JFPP is the opportunity to live in the community you are placed in. Because of the large amounts of students with placements at the Hospital, I stayed in student accommodation with 3 other JFPP students. Sharing the experience with other students is so great and really gives you the opportunity to learn from them. It is also great for emotional/car support when you really need to go to the supermarket but it is 46 degrees outside, and a 3km walk.

Despite my complaining about the heat, Broken Hill is such a beautiful part of the country and I can honestly say it is unlike anywhere that I have ever been before. Here are a few of my favourite things about Broken Hill:

- Most of the streets are named after elements or historically significant people.
- There is a massive old mine right in the middle of town, geographically splitting the town into different sides (which locals will refer to, so if you're going to visit you should probably learn which way is east and which way is west).
- The sky is so blue that it almost looks fake.
- There is such an excellent sense of community and the people are so lovely.
- Trivia night at the local RSL is excellent.
- The train museum – who knew trains could be so interesting?

Things I don't like about Broken Hill:

- It is hot
- A kangaroo tried to fight me AT THE HOSPITAL (they live there?)

I only got a chance to see a small amount of what the area has to offer, but luckily, I still have another 6 weeks of placements of go!

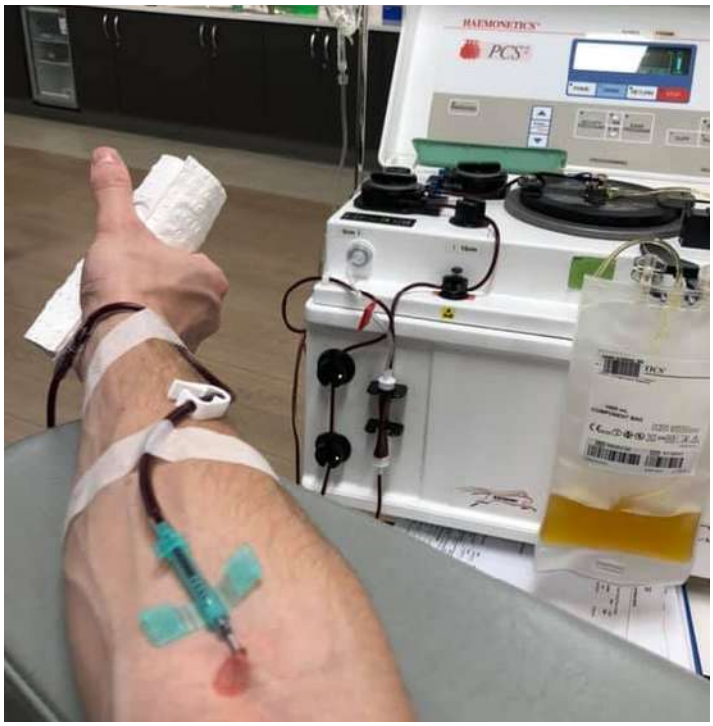
Finally, I would urge anyone who hasn't already to take the opportunity to do a rural placement somewhere throughout the country. Having grown up rural myself, and having already spent 2 weeks on a rural placement, I can already see the importance of rural medicine and how these communities can really feel like home.

VAMPIRE CUP

ELLE ROBERTSON AND LEAH MOFFAT

MD2, FMSS Community Director and AMSA Representative

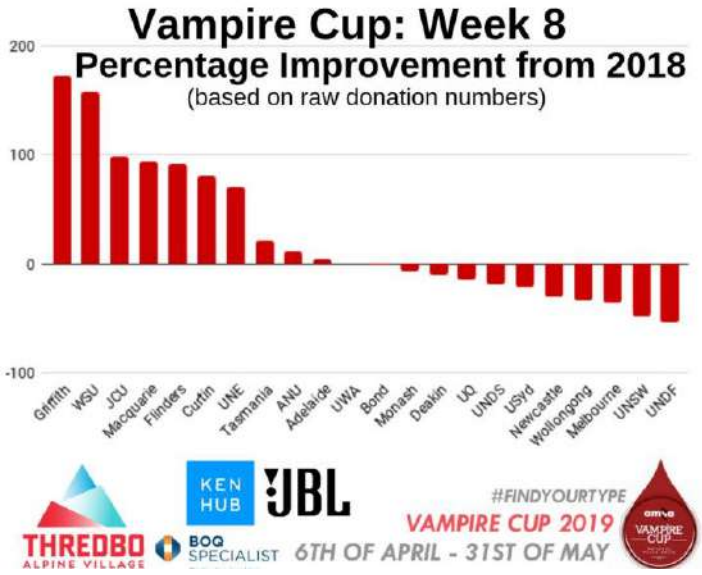
This year, from 6th April to 31st May, the Flinders community participated in the annual national blood drive, Vampire Cup. The Australian Medical Students' Association (AMSA) coordinates the drive, which involves twenty-two medical schools across the country competing to achieve the highest number of blood donations over the two months. Vampire Cup is run with the aim of increasing blood donations around the Easter period and start of the flu season - a time when each and every donation is vital!



Remarkably, this was the biggest year of Vampire Cup ever, with a total of 3461 donations nationally! There is no doubt that the vast line-up of Flampires willing to donate contributed to this number of donations! Overall, we are proud that Flinders accomplished a total of 115 donations, including plasma, platelets and whole blood donations. This has made 2019 the most successful year for the Flampires team. With each donation set to save 3 lives, that means we made an incredible difference to the lives of 345 members of society. Flinders placed 12th out of the 22 universities, a significant improvement on our 18th place last year.

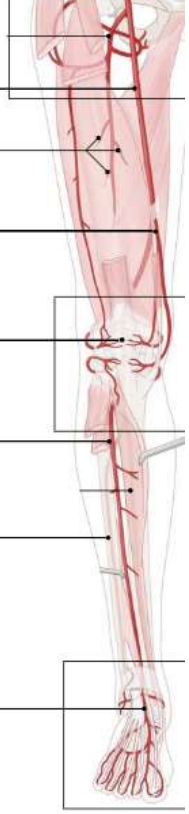
From the very first day of the competition, Flampires flocked to local donation centres. There were appointments booked right up until the very last day of donations. A special thanks must be extended to everyone who donated and, in particular, to those who donated on multiple occasions across the competition. We extend further thanks to the members of the Flinders community who encouraged friends, family and partners to become involved in blood donation. For many, it was their first time! Each and every donation, and each life saved, can be attributed to the participation and positive attitudes of the 2019 Flampires team. It was truly heart-warming to see a community of people come together and become committed to supporting society in a wider sense. The blood donations are important for people with cancer and blood diseases, anaemia, those undergoing surgery and childbirth, and people involved in trauma and accidents. It is important as medical students (and future doctors) that we understand and appreciate the role that blood donation has in the treatment of a variety of patients. It truly makes a difference to people's lives.

However, more importantly, blood donation is not restricted to just these 8 weeks! We want to encourage donations all year round, because the demand for blood donations never ceases. There are always people in need, and the smallest of gestures can have profound effects on the lives of others. It has been a joy to organise Flinders' participation in Vampire Cup this year. Thank you all for making it such a successful year! We can't wait to see even greater participation in future years and even more lives saved.



SOCIAL

34. Southern Adelaide Skin Society
35. O'Week
36. MedCamp
40. Health & Human Rights Group
41. General Practice Students Network
42. Flinders University Critical Care Society
43. Flinders University Surgical Society
44. Flinders University Rural Health Society
45. Health, Counselling & Disabilities Services



SOUTHERN ADELAIDE SKIN SOCIETY

MEL JIANG

MD2, SASS President

2019 is the inaugural year for the Southern Adelaide Skin Society (SASS). This year, we are very excited to be able to offer unique opportunities for students to develop a greater, in-depth level of knowledge and appreciation for the fields of dermatology and plastic surgery, complementary to the Flinders MD course. The goal of our events is to offer an opportunity for students to establish an educational bridge between the knowledge we learn in lectures and how to apply them to clinical practice. Our society will offer three immersive academic sessions in 2019 run by current doctors, past alumni of Flinders University and current MD students, as well as a clinical skills workshop where you can practice key skills needed for the wards. So far, we have had our Welcome to SASS intro lunch in March this year, which was a great meet and greet for our members, the Senior Committee and the incoming Junior Committee for 2019. Our latest event was an academic night on the 8th of May, where we were lucky enough to welcome Dr Gillian Marshman, the previous Head of Dermatology at FMC, to present to students, alongside junior doctors who facilitated quiz-based learning activities. Dinner, of course, was also provided! We would love to have you all involved. Our committee is very excited for a jam-packed year to come, and we hope you are too!

O-WEEK

NIBIR CHOWDHURY AND KIMBERLY LAI
MD2, FMSS O'Week Convenors

O'week ran over two weeks in 2019 to provide the new MD1s with an experience like no other! O'week marks the start of a long journey that new MD1s are about to take at Flinders and it is very important that O'week sets a nice tone for that journey. It is generally a week (in this year's case 2 weeks) full of social and academic activities for students to enjoy and use those activities to get to know the school and each other.

This year began with a challenge, as MD1s had a full academic schedule and there were 50 new places added to the cohort, however we managed to spread all activities over 2 weeks to prevent anyone from missing out. In all the activities we accommodated bonding between the MD1s as well as different year levels because we feel it is necessary to help foster intra-cohort bonds and friendships early, as many of the MD1s are coming from such different backgrounds. We believe the experience was well accepted and it was a successful endeavour.

We started the week with a big FMSS BBQ, where the MD1s had their first opportunity to meet the other cohorts. It was amazing to see the amount of engagement in the new cohort, we felt very proud! This was followed by a meet 'n' greet event that night where the MD1s could unwind after a long day at uni and mingle with the other year levels. We got our general knowledge hats on for the annual O'week quiz night and from the feedback we were informed that this event was a HUGE HIT among the MD1s. We hope it helped some MD1s get a few marks in PT1! Students were not only challenged intellectually but also physically with a planking and a grip challenge for which we had prizes donated to us by the lovely Flinders Fitness.

The first week concluded with some casual drinks and food at the Tavern after their first TBL which was a relaxing way to celebrate their first week in med school. The following week we had more society lunches and ended the week with a sports themed pub-crawl! The pub-crawl included 3 great venues with lots of drink specials and to top it off we had the senior years join in too as we combined Post-PT celebrations with the MD1 Pub-crawl. We had lovely volunteers as part of the welfare team and the MD1s had the best time. It was awesome seeing people who were strangers in the beginning of the week making friends with each other and embarking on new experiences together.

O'week was a great achievement for all FMSS committee members and we couldn't have done it without our amazing sponsors, people who donated prizes, staff members who came and supported our events, senior years who volunteered their time and above all the MD1s for their amazing engagement. We hope MD1s enjoyed the O'week as much as we did. We also hope the MD1s had an opportunity to cultivate a few friendships that they can lean on when things get tough throughout the next 4 years. We wish the new cohort all the best for the future and hope they enjoy each moment!

We just wanted to end this by welcoming any feedback on O'week, whether it be what you enjoyed or something we could have done better. This feedback will help us deliver an even better experience to future students.

MEDCAMP

JEMIMA STAUDE AND GRACE BERWALD

MD2, FMSS Social Directors

Post-TBL on Friday March 15th, a record breaking one-hundred-and-sixteen MD1s made their way to the beautiful Camp Dzintari. As the buses arrived at the camp, the sun was shining, chillies were ripening, drinks were chilling, playlists were maturing and MD1s and MD2s alike, were quivering with anticipation of what could possibly be the biggest weekend of the year.

After a delicious dinner, the MD1s got to know their teams and team leaders through several "team-building" exercises specifically designed to test the strength of team, hand-eye coordination and stamina. In the spirit of well rounded frivolities, all social awkwardness began to melt away (and socially acceptable dance moves too) as the first social night was well and truly underway. The theme 'When I Grow Up' saw students dressed as doctors, farmers, firemen and everything in between. It really makes you think of what could have been. Except for the guy dressed as a banana, not sure how that could have been but luckily you found medicine.

Academic stations kicked off a warm and sunny Saturday morning, with a variety of activities involving suturing, otoscopes, sphygmomanometers and definitely no shortage of fake blood. The MD1s faired remarkably well with the academic sessions despite the exhaustion of the previous night's dancing in the moonlight. It is safe to say, the future of medicine is in very safe hands (following several more years of training of course). A massive thank you to FUSS, FCCS and GPSN for all your hard work on the day. And another big thank you to google for teaching us how to spell sphygmomanometer. Everyone was then treated to a delicious lunch (thank you AMSA). The afternoon quickly developed a more competitive tone, as the teams realised they were fighting for more than just fun and friendship with their peers - there were bragging rights at stake now. Even a local snake came to watch the scavenger hunt which became so competitive it was nearly venomous (haha) (thank you snake catchers).

Later that afternoon, teams went head-to-head in a very sweaty sports day. Never have we seen such a dazzling display of athleticism/poor hand-eye coordination (those who were there can decide for themselves). This was followed by the Iron Stomach challenge. It was somewhat worrying to see how quickly people will eat some very questionable things when there's a prize involved, especially when they don't even know what the prize is. Then came the infamous chilli challenge. We don't know if it was the supposed "bad chilli season" or the incredible perseverance of the MD1s, but these brave participants made the chilli challenge look like a piece of cake. We can only hope they digested them as well as they ate them.

That evening, another delicious dinner was prepared by the kitchen crew to line the stomach before some intense boat races. They resulted in a very close finish, with a re-row occurring at one point. The tension in the air was palpable as was the scent of West End. In the end it was team dark blue that fought valiantly to become victorious against the other MD1s (hats off to pink team for racing one man down). However, it was clear that the MD1s still have lots to learn when they couldn't match the awe-inspiring speed of the all-star MD2 team. The boat races set the tone for the final social night, with the theme 'Anything But Clothes'. For the most part, costumes on this night were fun and creative, apart from a particular baguette in a place where no baguette should ever be. There's no doubt that the MD1s intended to go out with a bang, and this night had everyone dancing until the early hours of the morning. Before we knew it, MedCamp 2019 had come to a close. In the end it was the dark blue team that claimed victory in what can only be described as the closest margin in the history of all MedCamps. But in the end everyone was a winner, coming away with many memories (hopefully), copious amounts of knowledge and friendships to last a lifetime (or at least the next 4 years). And if even that wasn't enough there was also good lookin' free FMSS merch that made the weekend worth it.

It was such a pleasure to organise and coordinate an amazing group of MD2s this year. We are so grateful for all your help and MedCamp wouldn't have been possible without you. In particular we'd like to thank our awesome kitchen crew, Matt and Ys. You guys are life-savers. Finally, shout out to the MD1s for making MedCamp 2019 the biggest and best (if we do say so ourselves) MedCamp yet! You're a crazy but awesome bunch, thank you for being so enthusiastic.

Love Social (Grace and Jemima) xx


RICK


DIRECTOR
MILLS


twister


FLINDERS
MEDICINE


adidas
CHEVROLET
KNVB

HEALTH AND HUMAN RIGHTS GROUP

ELLA COCKBURN
MD4, HHRG Co-President

This time last year, I found myself in a very different place in my life. Quite literally, I had entered into the quaint town of Strathalbyn - a mysterious place, nestled in the outskirts of the Adelaide wine region. Though only an hour out of Adelaide, Strathalbyn continues to desperately cling to its rural roots. The hospital there is, for the most part, run by a handful of hardworking, dedicated and inspirational individuals, whose working lives are interwoven with their personal ones. It was here I spent the year, developing my clinical skills, overcoming my fear of talking to patients, and realising that resource-restriction, and social isolation, are very much true entities in the rural world. Having successfully regressed some of my social skills, I finished my PRCC year feeling exhausted, yet humbled by the experience. It was from this place that I returned to Adelaide with a desire to share what I had learnt, and to subsequently raise awareness about the human right to equal access of healthcare. So I thought, no better person to talk to than my good ol' friend Dan Ring about jumping on board the HHRG bandwagon, and here we are!

HHRG is striving to educate our peers, and promote discussion surrounding a number of issues. Ultimately they all fall back on the same principle - everyone, no matter where they are from, how they identify, or what hardships they have endured, has the human right to equitable healthcare. It is our vision this year to broaden HHRG's horizon and incorporate more global health initiatives. Similarly we hope to run more events focusing on Indigenous health, disability care, the environment, reproductive rights and LGBTQI inclusion. Starting our year off nicely, our O'Week event (catered by a purely vegan company) set the tone for what you can expect from us this year. We hope to stay true to our core values, and to continue to promote worldwide issues through our own initiatives.

Given the state of the political climate worldwide, and the implications this is having on equality, on the environment and every man and his dog, we hope that our society can play a meaningful role in raising awareness, and promoting change.

GENERAL PRACTICE STUDENTS NETWORK

EMILY DRUM

MD2, GPSN President

GPSN Flinders has been busy this year promoting all things general practice! We have been working hard, organizing several events across a variety of year levels.

We began the year at MD1 O'Week where we gave out our famous goodie bags supplied with a variety of items from our fantastic sponsors. It was a great opportunity to meet the MD1s and welcome them to the med family, and the world of GP!

Next, we all hopped in a car and travelled down to Med Camp to present otoscopy clinical skills teaching. Here, participants were given the opportunity to learn this vital GP skill used in everyday clinical practice. It is our aim for this year to introduce as many clinical teaching opportunities as possible, to give our members a real insight into the role of a GP, and to showcase just how exciting this career option is.

Shortly after, GPSN was back at FMC hosting a stall at the Clin Sci O'Week. Here, students were given the opportunity to gain a bit of insight into GP as a career pathway of choice. It was great meeting the cohort and we wish them the best as they transition through the degree.

Finally, GPSN has welcomed our new Junior Committee who are keen to contribute to the society. We are so excited to be working with our team and cannot wait to see what new ideas we can bring to life.

GPSN Flinders has also continued to be involved with GPSN at a national level. I have been meeting with other representatives from all medical schools in Australia, as well as representatives from GPRA, to ensure that we are working towards fostering an interest in GP and offering opportunities to those interested in this career pathway. We are working on some amazing projects, so continue to watch this space!

This year we have also upped our online presence, especially through our Instagram page @gpsnflinders. Follow us for high-yield fast facts, club updates, and competition announcements.

We have a busy year planned, with our GPSN Movie Night, Clinical Skills Day, and Not Just a GP Night all coming up in the next few months. Make sure you keep a look out online for updates on these events and get excited!

FLINDERS UNIVERSITY CRITICAL CARE SOCIETY

YSABELLA TYLLIS
MD2, FCCS President

Flinders University Critical Care Society (FCCS) has leaped into 2019 with a great start. We are continuing to smash our goals in bringing our members some fun and exciting new information and skills in critical care. Our year began with a member recruitment process, in which we have nearly doubled our member base since 2018. This has meant maximum involvement in our Dress Your Best fundraiser days. We look forward to involving everyone in the exciting events that we have coming throughout the year.

Early in the year, we held a two-part ECG intensive program, taught by SA Ambulance Intensive Care Paramedic and ALS2 Instructor, Grant Gallagher. This event involved taking ECG's 'back to basics', and then building knowledge from there through some hilarious (yet effective) interpretation tricks, along with some valuable knowledge that lots of students have been able to take to wards and Progress Tests. This event was very well received by students, with many requesting more of these nights throughout the year. We also recently held our Advanced Airways night taught by four fantastic anaesthetic consultants, who gave students their tips on performing skills such as intubation, video laryngoscopy and surgical cricothyroidotomy. They then provided the opportunity for some awesome hands-on learning. We look forward to holding the rest of our clinical events throughout the year, including trauma night, cardiac night and airways night, all coming up in second semester.

Our team set up a car crash scenario for the MD1s at MedCamp, which had no shortage of fake blood or over-the-top acting skills, and was easily the (self-proclaimed) highlight of the weekend. For the first time, we submitted a team into Adelaide Students' Society of Critical Care's Emergency Medical Challenge, and our FCCS team were lucky enough to score the win!

Dress Your Best has had its best involvement in FCCS history so far, with record breaking numbers of students donning their best outfits for our cause. So far, we've seen TBL rooms full of sports players, a sea of Hawaiian shirts, a murder of red clothing, a rainbow of clothing for IDAHOBIT day and some crazy hats. This is all in an effort to raise money for some emergency equipment (such as ECG machines) in the Muhimbili Hospital in Tanzania. The expansion of our socials has also meant fascinating educational posts to keep our followers well-informed on everything critical care, and an exciting social event in the making for all our awesome members.

Keep an eye on our social pages for all the latest information on how to get involved with our events and fundraisers, and to check if you've won an UpCo voucher by Dressing Your Best!

FLINDERS UNIVERSITY SURGICAL SOCIETY

SUNNY PATIL
MD2, FUSS President

FUSS has been highly active in 2019, maintaining our primary goal; to continue to provide students with greater exposure to surgery as a speciality, and furthermore, provide opportunities to learn and practice advanced skills. In 2018, we coordinated a variety of successful events including Women in Surgery, Suture Night and Surgical Careers Night; all of which we intend to bring back in 2019, bigger and better! FUSS boasts an almost 100% membership rate amongst Flinders University medical students, with more than 500 medical students fully registered for the duration of their medical degree. Furthermore, we are also lucky to have an extremely active alumni page, with many members continuing to network via our resources.

So far in 2019…

FUSS commenced 2019 with a huge start; the recruitment of the MD1s. We were fortunate to have over 120 sign-ups on the O-Week lunch itself! This was a highly successful event with students being able to have some relaxation and socialising time on the rooftop balcony, all with a free champagne and pasta lunch. Following this event, FUSS provided students with an opportunity to learn some laparoscopic stimulation skills at the Royal Australian College of Surgeons. This was really beneficial for students as they were able to have some exposure into laparoscopic stimulation and were taught skills by an expert in the field.

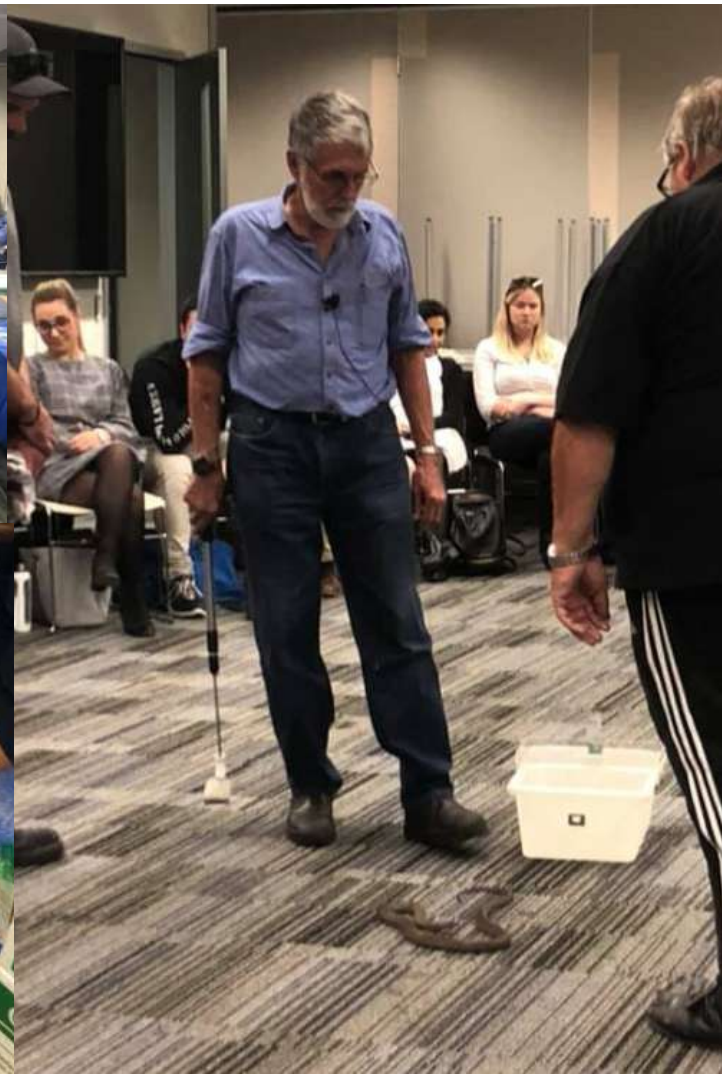
Med Camp was the next FUSS opportunity to provide students with an insight into some surgical skills and here we focused on suturing technique. Our key aim was to give students a feel of the tools and equipment utilised in basic skills such as suturing. We had 6 lovely volunteers from older year levels helping out the MD1s with this activity, providing hands-on assistance, which the students found really useful. Finally, our last event for April ended with an expert anatomy teaching session by Roland White, a prospective surgeon, who provided students with an extremely useful and interesting talk based on cardiology and the clinical context. We also gained a junior committee after a record number of attendees at our AGM, and we look forward to bringing them into the upcoming events! We aim to continue our high quality (and quantity) of events, with some of the year's sold out events coming up: Suture Night and Scrub Crawl! Stay tuned.

FLINDERS UNIVERSITY RURAL HEALTH SOCIETY

SAM PAULL
MD2, FURHS President

FURHS is a multidisciplinary society with a rural focus that encompasses all of the health disciplines at Flinders University. We run a number of events over the year including; rural high school visits, Indigenous engagement days at Point Pearce, interprofessional networking days and a Wilderness Health night. One of the highlights for the year is the Rural Doctors Workforce Agency's (RDWA) Royal Flying Doctor Service (RFDS) Ride Along Program, which allows students from Medicine, Nursing & Midwifery to join in with the RFDS for a day, getting to learn about the great work they do in rural and remote Australia, and getting to fly out to locations around rural South Australia. FURHS also runs rural high school visits, where university students across all of allied health, nursing, midwifery and medicine get the opportunity to teach high school students about their chosen discipline and encourage them to follow a career in health.

Students who want to get involved should like us on the facebook page and are welcome to come along to our monthly committee meetings.



INTERVIEW WITH HEALTH, COUNSELLING AND DISABILITY SERVICES, RE: MEDICAL STUDENTS

SAI LEKSCHMI CHANDRAMOHAN
MD1, Publishing Officer

It is known that medical students have some of the highest rates of stress, anxiety and depression. How can the counselling services help medical students in particular? Are any services tailored to our specific needs and circumstances?

The Counselling Service is familiar with the research around stress, anxiety and depression for medical students and as a result has implemented a number of strategies to address these issues.

A range of workshops are conducted for first year medical students that focus on wellbeing, resilience and self-care.

We are also looking at developing a progression support program for medical students that focusses on a coaching model to assist students to develop strategies to keep them moving forward with their studies. Discussions with the College have already commenced.

Whilst counselling services are standard across the disciplines, we are aware of the specific requirements and stressors for medical students so can tailor sessions to address these issues.

Counselling Services are available to students either face to face, by phone and Skype and we also have a range of options for those studying in regional and remote locations.

What sort of problems can we come to you for? E.g. study, personal, family, friends

Students come to the counselling service for a variety of reasons which can be academic and/or personal. Some common academic issues that students present with are struggling with workload, procrastination, perfectionism and anxiety. Personal issues can include mental health issues such as depression and anxiety, relationship issues and dealing with difficult life circumstances such as family and/or friendship issues.

The advice we give to students is to seek assistance earlier rather later. If in doubt come and talk to someone from the Counselling team and if we are not the appropriate service we can look at options for a more appropriate service.

What are some typical forms of ongoing support that you can offer? E.g. making action plans/reviewing mental health status/change in assessment conditions?

In the first instance the service offers a thorough assessment to determine what are the issues and what services and supports might be of assistance. As a result of this assessment you might be booked in for further counselling appointments, referred to another health professional within the service such as a GP or Disability Advisor, referred to another support service within the university or to an external service such as a private psychologist.

Students with a disability may require an Access Plan which outlines the reasonable adjustments necessary to assist them with studies. A 'disability' can be a medical condition, mental health condition, learning difficulty or any disability that impacts on study.

We also offer a range of programs such Mindfulness for Academic Success and Mindful Yoga https://oasis.flinders.edu.au/mental-and-physical-wellbeing/

Can we pop in or is it advisable to call/book online first?

Students who are new the service can register for counselling support using this online form - https://students.flinders.edu.au/student-services/hcd/counselling/new-client-form or email counselling@flinders.edu.au or phone 8201 2118.

If you've been to the service before and are a returning client, you can call 8201 2118 to book a new appointment.

If it is a crisis during business hours, students can call 8201 2118 or Out of Hours, students in crisis should call our Out of Hours Crisis Line on 1300 512 409 or text 0488 884 103.

Since our timetables are pretty busy, can we usually get an appointment in the same week?

Counsellors respond to new requests via the online form typically within 24-48 hours. This is done via email or phone (or often both).

During this first contact, the triage counsellor aims to get a sense of what are the issues and suggest first steps. This might be to book in a face-to-face counselling appointment, or a referral to another service within the university or an external service.

Sometimes the issue can be resolved in that first phone contact.

There is a waiting time for the first f2f appointment (ranges between 2-4 weeks), so this first phone contact is very important. However, any issues assessed as urgent can be offered a same day service.

What can we generally expect once we have booked in to see a counsellor and walk in through the doors for our first appointment?

Most of the appointments are at the Bedford Park Campus, Level 3, Student Centre.

There is a reception/waiting area where all students need to present to the front counter.

Let reception know you have arrived and they will get you to complete a registration/consent form. This includes the conditions of service and consent for us to collect information as part of the service we provide.

Students wait in the waiting room until their counsellor comes out and calls their name (first name only). Counselling appointments are in private rooms, with no visibility from the reception area.

Often, medical students are hesitant to visit the counselling services due to fear of negative stereotyping around mental illnesses, or a fear of peers and staff finding out. Are notes taken during the counselling session? Does the School of Medicine or any other staff member access them?

Notes are taken during sessions and stored in a confidential patient information system called Genie. This system is separate from the university system and only staff from Health, Counselling and Disability Services can access them.

How are follow up appointments discussed and decided upon? Do we see the same counsellor each time? How many free follow up appointments can one get access to?

Students can access up to 6 counselling sessions in a year free of charge. Typically you will see the same counsellor over the course of those sessions. The need for and timing of follow-up sessions is decided collaboratively between the counsellor and the student. If a student requires additional sessions then the counsellor will talk with the student about options around this.

Will accessing counselling services have any effect on our progression through medicine?

Accessing the counselling service generally has a positive effect for students and can assist in progression through university by assisting them to develop study skills.

There may instances where a student's mental health or personal circumstances are significantly impacting on their studies. The Counsellor and the student will discuss the options available to the student and make a plan for the way forward, in these cases students sometimes decide to put their studies on hold.

What would you advise to a person who is struggling to manage their anxiety and stress levels at this moment, but thinks it's "not the worst, yet"?

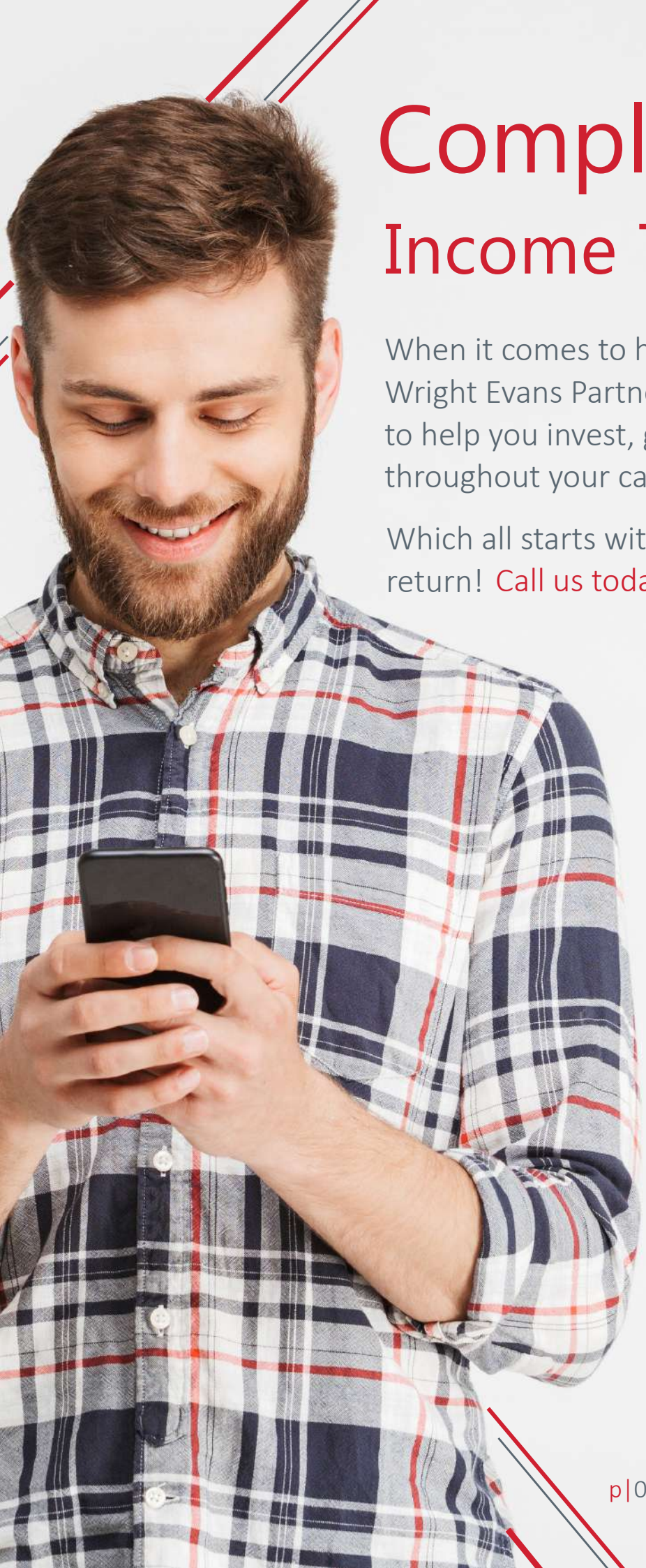
Start by looking at your self-care. Self-care isn't just whether you are taking time to relax, it is actually about whether you are investing appropriately in the various aspects of your life that produce health, wellbeing and productivity. We have written a guide on it - https://blogs.flinders.edu.au/student-health-and-well-being/2018/07/25/dr-gs-guide-self-care/

Second, look at what solvable problems you are facing that are causing your anxiety and stress. For example, a common problem students face is being overwhelmed by the amount and complexity of the work they need to do. The solution? Get better at studying by using evidence-based study strategies - https://bit.ly/2J4QVnG. Whatever the problem(s), look to see what practical solutions are available and don't be afraid to reach out and ask for specific help in solving them.

Third, take the advice of your future self. When you become doctors you will want your patients to be proactive in addressing any health issues early. The same advice applies to you. Problems of an emotional or psychological nature are always best addressed early. This doesn't necessarily mean reaching out for counselling assistance straight away. We are very lucky in Australia that there are some good anxiety/stress management programs online for free or low cost. A couple of examples include: https://thiswayup.org.au/ and https://mindspot.org.au/. Try one of them first. If that isn't helpful, consider reaching out to your GP, one of ours (https://students.flinders.edu.au/student-services/hcd/health) or one of our counsellors - https://students.flinders.edu.au/student-services/hcd/counselling

Waiting till a problem becomes the 'worst' version of itself only sets you up for a more difficult road back to health.

Note from Marketing Director: space at end of magazine, so unashamedly just put my dog, Kamachi, at the park playing with a stick.



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