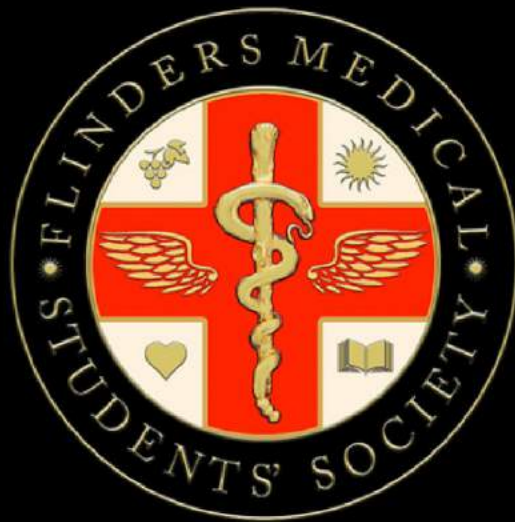


2022 | ISSUE 1

PLACEBO





THE TEAM

We wish to give a huge thank you to all the contributors for submitting their amazing work and taking time out of their lives to share something genuine with us.

The focus for this year's issue was 'Medicine and Society'. Though broad, this year's theme encompasses the work of Medicine that is in service of others and around the challenges and complexities that come with this good-intentioned devotion, for society and for the healthcare providers themselves.

Through engaging with our contributors works, we learned to re-enforce an important lesson; that doing a good deed is incredibly simple. There is very little money and very little time that is needed to do something kind for another human being. Something that is easy for us to do, can be life-changing for someone else.

Humbled by the passionate devotion of others in the service of humanity we reflected a lot on our future medical journey and endeavours, and hope that our readers also find something valuable within these articles.

Svetlana Astashova (Publications Director MD2)

Noreen Haidar Khan (Publications Officer MD1)

September 2022

Special thanks to **Rata Sirimaharaj** (MD1) for lending her time to help us with Placebo

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Mark Groote

Susan O'Brien

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Tom Cliffe

Jaida Buck

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Evan Pargin

Naomi Gamage & Amy Booth



PLACEBO

This 2022 Issue of Placebo magazine brought to you by the Flinders Medical Student Society features the following submissions.

In medicine, countless individuals sacrifice their time and devote themselves to the selfless care of others but how can we ensure that the work that we do brings about the most amount of benefit to those that need it? A question explored in **Tom Cliffe's** article about 'A Medical Perspective on Effective Altruism.

On the nuances of peer-work and the complexity of the mental health we have articles by **Adan Richards** and **Dr. Susan O'Brien**. They both bring a wealth of experience and deep knowledge about these topics to bring us contrasting and thought-provoking articles.

Is it okay to tell a patient they only have one day to live? **Rakad Alghizzi** explores the ethical dilemma around truth-telling in medicine in her article. She also curated amazing photos for the Placebo magazine and we're thankful for all her submissions.

Throughout Australia, there are amazing volunteer organisations that provide services for the communities and boundless learning opportunities for their volunteers. We hear about the amazing work of health volunteers with St John Ambulance, directly from their CEO **Mark Groote** and about State Emergency Service from the ceaselessly devoted **Evan Pargin**.

Australia is home to a diverse range of cultures and religions, the same goes for our healthcare professionals. We shed some light on the work of Muslim medical professionals in Australia through our interview with the President of the Australian Islamic Medical Association (AIMA), **Dr Muhammad Kahloon**.

Flinders Medical student **Jaida Buck** shares a beautifully written creative piece about her experience learning from the 'silent teacher'.

What do you know about attention deficit hyperactivity disorder (ADHD) in adults? What about in women? **Shannon Waters** tells her unexpected story of challenges and victories after being diagnosed with ADHD as a medical student.

Finally, we welcome a new medical student society into our Flinders team and hear from the passionate co-presidents **Naomi Gamage and Amy Booth** as they share their vision and goals for the Flinders University Paediatric Society (FUPS).

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PRESIDENT'S ADDRESS

I would like to acknowledge the Kurna people, the original custodians of this land, and recognise the relationship between Indigenous people and the lands and waters of the Adelaide Plains, on which we learn and grow every day.

Advocacy, culture, education, support. These are the four domains that Flinders Medical Students' Society (FMSS), in keeping with its applaudable high standards, has offered for 47 consecutive years. My name is Kritika Mishra (she/her), and it is truly a privilege to have been elected the President of FMSS in 2022. Our committee goals this year include maintaining a healthy and engaging environment, ensuring cultural safety, communicating transparently and effectively, increasing our impact on local communities, and facilitating vertical integration and camaraderie between all MD year levels and Flinders alumni.

Leadership is a complex, challenging and inspiring process, which has been practised by Indigenous communities for thousands of years. Unlike the English metaphor of leadership, which characterises a leader as the apex of a vertical hierarchy, in many Indigenous communities, a leader is on the same horizontal plane as the community they represent. As the requirements of the community change, the leader must demonstrate flexibility and adaptability to ensure proactive, accurate representation of those requiring their advocacy. This inclusive and dynamic model of leadership is something that our committee has strived to demonstrate this year, and its importance is accentuated by the evolving needs of our population today.



Specifically in the healthcare field, every day there is a new, unexpected challenge, and every patient presents with a unique situation. If our profession does not highlight the importance of flexibility in leadership, I am not sure what does.

Despite the hard work our committee members demonstrate daily, I often get asked, “so what does FMSS actually do?” Initially, I felt quite overwhelmed by this question, because the list is limitless. On reflection, however, I now smile and almost feel satisfied by a query as such. This is because I have learnt that the role of a leader is not always to be seen, heard or known. In fact, the most successful leaders are often those who people do not even realise exist. The question, “what does FMSS do?” is almost a testament to the fact that behind the scenes our committee is advocating effectively, organising thoroughly and addressing concerns so proactively that sometimes, you may not even understand that we are anticipating your expectations and needs before they are even expressed. In saying all of this, however, we are in no way perfect. Accepting that no leader can be perfect for all has personally been one of the most challenging aspects of my role this year. If we ask all of you what you look for in a leader, you will all have very different answers. However, if you ask individuals what they do not want in a leader, the answers may come to you more naturally. This highlights the challenge of leadership – how complex it is to integrate and pragmatically manage and prioritise everyone’s very different expectations.

At FMSS, our leaders are driven by their passion for giving back, an admirable and generous quality to possess. As President, I am proud to see what our society has achieved, and continues to achieve this year, and hope that together we can leave a lasting and positive impact on our medical school and its students. We are here to empower and support our members throughout these complex and challenging times, reminding them of the importance of companionship and collegiality, so that 1.5 metres doesn’t feel like such a long way away.



Kritika Mishra
Flinders Medical Students' Society
President

Peer work in Mental Health

About 1 in every 5 Australians experiences mental ill-health in any given year, however, these people may often feel misunderstood and unheard. Peer work strives to bridge this gap and provide support that stems from the peer support worker themselves having lived experience of mental ill-health. This rewarding work, however, does not come without its challenges and internal controversies. Adan Richards, a current PhD candidate and a peer worker with extensive experience, is shedding light on the nature of his work for us in this personal piece.

By Adan Richards

Life is hard for many of us, for many reasons. Many experience distress, and use mental health services to try and feel better. Others are forced into the mental health system. Whether by choice or not, service users have mixed results, and we are far from having the best care possible for people. 'Peer work' is one attempt to do the job of helping better.

I have worked in lived experience roles as a public speaker, group facilitator, representative and peer/community worker. My job descriptions seem vague, the role is often poorly understood, and the value of my work unrecognised. Usually immediate co-workers see the value, but within structures that don't allow lived experience to operate uncensored. The 'peer work' that I try to create is often not about sharing a common story together. In fact, that my largely privileged life story would be directly helpful for someone seems risky, a tool to be used sparingly and carefully.

I use 'scare quotes' around 'peer work' (as a peer worker), because I remain uncertain about the usefulness of the distinction. Having a job title of some description helps to build professional power, which gets you paid. Every other discipline does this.

However, there are many disciplines through which lived experience, stated or unstated, job described or not, is invaluable in serving people seeking help. It is instructive that most professionals I know have lived experience, but this is not recognised in their job title. Of those, many use this experience directly through disclosure (sometimes having to hide that they do this) and indirectly to inform how they treat people. These practices are held back by antiquated ideas of professionalism that create an artificial divide between vulnerable people and societies 'helpers'.

If highly experienced people of all disciplines were able to openly use lived experience in their work, then a symbiosis of professional and lived experience could be unlocked. This would be de-stigmatising for service users and everyone as the well-



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MidJourney™ under a CC BY-NC 4.0 licence.

unwell divide would not be matched inside of workplaces by the respective clinician/peer worker divide.

For me 'peer work' as a movement is welcomed in forcing these issues out in to the open but does not provide a final answer for how lived experience can be valuable to others. The professionalisation of any job, as is currently happening in peer work, brings along issues shared with other disciplines.

The very idea that I could be there to help someone is something to be considered carefully. The heroism ascribed to being in a helping role can be blinding and dangerous.

There is one version of events where my work reduces suffering in the world, and pushes people towards emancipation from misery. The other is manipulation, part of a behavioural modification strategy, to turn people into economically productive units, or at least lower their financial 'burden' on society. It is important to understand that being paid to do work, and being told it is a morally righteous thing to do, can cloud judgement about the work's ethics.

I'll give a relatively low stakes example. Most people who use mental health services are asked to come up with goals. Sometimes I'm asked to develop goals with people. I understand that if someone asks this of me, I make the goals up out of politeness, as I have done in the past – this satisfies everyone but doesn't help much.

In the past I believed that I should have goals, even though they never helped; real plans I had in life went ahead without writing them down.

It's an example that begs a broad question for all who work in mental health. In our actions purported to help people, who, or

what are we serving? Are goals for the service provider to lobby for funding, the worker to satisfy their procedures and keep a manager off their back, or what a person wants? I am not anti-goal, that would be pointless – goal setting is sometimes useful, often coercive. If a person is being coerced, goals can become perfunctory or performative.

In such a minefield, what does it mean to do good work?

Most often, my work has involved understanding (trying to) what influences the words spoken between myself and others. Considering with the greatest care; my actions, verbal and non-verbal, the space we choose to sit/stand/walk, the people and purpose that bring us together, and the power structures that censor what we can and can't say to each other.

In doing so honesty is my objective, hoping that a person feels safe enough to be honest with me. Often the most important moments of honesty admit that the 'treatments' someone has received are often harmful, bizarre and unjust. In this work every moment is important, there should be no arbitrary line when kindness and compassion are offered and ceased.

As R.D. Laing said, "...the way we treat one another is the therapy." Through first-hand experience, lived experience workers are uniquely placed to know the subtleties that make each moment with a person a potentially safe one – they have lived many moments from the other side of the fence.

There is another side to doing good work, through advocacy. This is not just advocating for a person to live a meaningful life on an individual level, but to understand that the current paradigms in mental health fail to properly recognise



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social injustice as a cause of distress and extreme states*. The dominant focus is biological.

The Diagnostical and Statistical Manual of Mental Disorders 5 (DSM-5, now DSM-5 TR) is the dominant classification system for diagnosing 'mental illness' in the western world. Because it was assumed that disorders in the DSM were 'illnesses', and biology would eventually confirm the validity of these diagnoses, most research in the field has been focused on biology. The table below details one example of this (Table 1).

If this research had been successful, a schizophrenia diagnosis would likely contain biological markers as diagnostic criteria. Alas, the search has been a failure, and most diagnoses in the DSM-5 TR contain no biological markers. If disorders are included in the DSM with biological markers, it is for brain injuries, syphilis, dementia or others similar, which all have an essential biological feature.

Finally, there are associations of both distress and extreme states, with bad events in childhood and material deprivation [2]. More than a quarter of the poorest fifth of Australians have high levels of distress, compared to just a twentieth of the richest fifth [3]. This is obviously not because less wealthy people are biologically different from birth.

If you incorporate this into practice, then you are more likely to see that the person in front of you is much like you, not broken or ill, but from different circumstances.


Considering this and many other issues, it is important that 'peer work' and lived experience work (and really everyone) stand in solidarity with critical discourse about how we deal with distress and extreme states in society. These are problems that we all share, pain that hides deeper context, stories that are untold and unheard, leading us back to our world's.

*Extreme states are what others might label psychosis.

Table 1: Proportions of 'schizophrenia' research investigating child abuse, poverty, biological causes and drug treatment [1]

	Studies before 2000	% of all schizophrenia research	Studies during 2000-2009	% of all schizophrenia research
Child abuse and neglect	142	0.3%	120	0.4%
Poverty	462	1.0%	242	0.9%
Biological causes	8,023	16.7%	7,458	27.6%
Drug therapy	7,832	16.3%	6,345	23.1%

1. Read, J., Bentall, R. P., & Fosse, R. (2009). Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. *Epidemiology and Psychiatric Sciences*, 18(4), 299–310.
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3. Isaacs, A. N., Enticott, J., Meadows, G., & Inder, B. (2018). Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas. *Frontiers in Psychiatry*, 9, 536.
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• **Liz Abraham**
Medical Student
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▶ **Yonina Yang**
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ST JOHN AMBULANCE: WHERE TO FROM HERE?



With COVID-19 having dominated our lives for the past two and half years, I often stop and try to think what it was like before COVID. The global pandemic has affected our lives in many ways and for an organisation like St John Ambulance, it has seen us need to adapt, strengthen our resilience, and be agile to the community needs. It has also seen us evolve our medical capability and response, and challenge typical clinical servicing.

If you were to think what the 2022 Commonwealth Games, World Youth Day (Australia's largest single day mass gathering in 2008), an Eye Hospital in Jerusalem, an internally acclaimed disaster and mass-gathering health researcher, and a current Australian of the Year recipient had in common, it would be that St John Ambulance has strong ties to all.

St John Ambulance's role in medical services has a wide reach across the world – and has formed itself as synonymous with high quality clinical services in some unlikely settings.

St John Ambulance is a self-funding, charitable organisation active in all States and Territories, dedicated to helping people in sickness, distress, suffering or danger. St John Ambulance has enjoyed an active role for more than 130 years in Australia. Providing services to a broad scope of the community, St John Ambulance is the country's leading supplier of first aid products, services and training. Each year we deliver 1.2 million hours of voluntary community service, train 500,000 people and treat 100,000 people in Australia at public events annually.



In South Australia, St John Ambulance is largely known as a provider of choice for its provision of event health and medical services, providing an exceptional level of safety and assurance to event organisers and communities in times of need.

The acute need for community medical services, particularly for mass gathering events, has meant that St John Ambulance has needed to evolve what it does, including its scope of clinical practice for its staff and volunteers. This may mean that St John Ambulance finds itself providing basic life support at small community events, higher levels of care where the risk profile of the event and environment warrants through to extended care services through the deployment of registered healthcare professionals. This reflects modern expectations from those attending events and community expectations for managing risk and ensuring people remain safe.

St John Ambulance also plays a critical role in supporting affected communities during major emergencies and disasters with COVID-19 related deployments as well as supporting affected communities during the



Cudlee Creek and Kangaroo Island bushfires of 2019/20.

St John Ambulance worked closely with SA Ambulance Service to provide around the clock primary health and emergency care at emergency Staging Areas and Relief Centres to support emergency service personnel, other responders and community volunteers, as well as the vast many displaced, affected community members.

A core consideration of modern medical response is that it can be provided outside of



a typical clinical care setting. St John Ambulance members, including healthcare professionals, provided support to the local Kingscote Hospital on Kangaroo Island ensuring that hospital avoidance measures were in place, as well as a robust pre-hospital triage and assessment process to ensure that the hospital could continue to function effectively, despite the significant increase of population to the Island, as well as that many of the hospital staff were personally affected by the fires.

St John Ambulance was able to extend their support to the emotional and psychological wellbeing of affected communities at both the Cudlee Creek and Kangaroo Island fires, through the deployment of personnel trained in Mental Health First Aid and first aid. COVID-19 has seen healthcare operations and disaster response shift its focus around the welfare and wellbeing of its own members through increased infection control training, donning and doffing of personal protective equipment, especially the fit testing and wearing of P2/N95 masks and waste management considerations. These issues are much more carefully considered now than they were just three years ago.

St John Ambulance has been a long-trusted organisation that has supported and developed healthcare students and registered healthcare professionals alike. With a robust clinical governance framework, including credentialing and skills/qualification recognition as well as drug and ambulance licencing with SA Health, St John Ambulance provides a positive and welcoming opportunity for those looking to provide clinical services at mass gatherings, community events and disasters.

St John Ambulance is embedded in the South Australian community and high-quality clinical care remains a key organisational priority. Perhaps you are interested in volunteering to assist this community effort and complement your clinical skills with a volunteering role that is unlike any other. Are you up to it?



Mark Groote
Chief Executive Officer, St John SA

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MENTAL HEALTH AND THE MEDIA

Several years ago I retired from 47 years of medical practice. During that time I worked as a GP, family therapist and, for 25 years, as Counsellor for Flinders University medical students. Over those four decades I have seen a major shift (mostly for the better) in public recognition of mental disorders and in their media representation.

Looking back, I realise that in the 1970's mental disorders were more likely to be regarded with denial, secrecy and shame. Expressions of grief were discouraged. A person who barely mentioned death of a family member could be described as 'coping really well' The social milieu was different. Consensual sex between gay men was then a criminal offence and until 1973 homosexuality was classified as a mental disorder. Now LGBTQ+ individuals can legally marry and are full members of our society.

The **2021 Australian Census**, a whole nation study, revealed that chronic mental health disorders, (as diagnosed by a health professional) are the most common health problem, affecting about 10% of the population.

In the 2021 National Study for Mental Health and Wellbeing, roughly 20% of the Australian population had consulted a health professional about their mental health, that year. Compared with the previous study, in 2007, this was a 40% increase (the double whammy of COVID-19 and climate-related disasters has most likely influenced this).

Rates were higher among 16 to 24 year olds and higher among females than males. Anxiety disorders were most common, followed by depressive and bipolar disorders and then substance abuse disorders. General Practitioners were consulted most often, then psychologists and psychiatrists Another 600,000+ individuals had sought help on-line from groups such as Beyond Blue, Lifeline, and headspace.

A free online mental health check tool is being developed to enable a conversation to be started with a health professional.

How are mental disorders diagnosed?

Psychiatrists most often use the increasingly controversial Diagnostic and Statistical Manual of Mental Disorders, edition 5 (**DSM-5**) – a classification and diagnostic tool produced by the American Psychiatric Association. The DSM started 70 yrs ago as a 30-page pamphlet and morphed into a 900+ page juggernaut by 2013.

'The DSM quickly became the basis for the acceptable scope of thinking about mental disorders among researchers and clinicians alike. It was institutionalized among all mental health professions, government bureaucrats, hospital administrators, mental health educators, advocacy groups, pharmaceutical companies, the insurance industry, and the judicial system. Patients, too, acquired a new language to interpret their distressing conditions and explain their emotional lives. Specific diagnoses became foundational for mental health practice, research, and theory' [1].

The recently updated **DSM-5-TR (Text Revised) – March 2022** has reframed many of the formerly discrete diagnostic categories with greater emphasis on culture and gender. There is also a more developmental focus on how disorders may manifest differently across the lifespan. 'Disorders' are now arranged on a spectrum of severity. For example, several separate diagnostic categories have now been condensed into Autism Spectrum Disorder (ASD). However, there is still a bewildering array of diagnoses.

In an attempt to be inclusive with the use of words such as 'atypical', 'unspecified' and 'borderline', has it made some diagnoses confusingly vague?

Do diagnoses lead to appropriate treatments and better outcomes?

Individuals and society clearly benefit from diagnoses and treatments of major disorders such as schizophrenia, major depression and bipolar disorder. Specific diagnoses are also essential for access to disability support pensions and in legal compensation cases.

Does the media seize upon vague/minor diagnoses and over-apply them?

Early identification of autism is vital in obtaining valuable services. On the other hand, it has become common for the term 'on the spectrum' to be loosely applied to a person who may simply be reserved or shy.

Are some jumpy kids wrongly labelled with ADHD (Attention Deficit Hyperactivity Disorder)? Whatever does 'a bit borderline' mean?

As a GP, family therapist and medical student counsellor with a special interest in mental health, I found it much more useful to identify the main presenting problem and the person's potential influence over it than to pursue a specific diagnosis. Life events such as falling in or out of love, losing a family member, job or accommodation powerfully interact with anxiety levels, confidence, mood and motivation and there are many useful approaches, including medication, to improve the balance of these.

Accurate diagnosis is essential for first presentations and ongoing management of major mental disorders.

What role does the media play in depicting or representing mental disorders?

In film and television drama, in just a few decades, simplistic depictions of Good, Bad and Mad have evolved to a more nuanced mirror of society, often celebrating the Antihero (the main detective is now more likely to have a failing relationship and possibly a substance abuse problem).

Over the last decade, there has been a proliferation of Australian television programs which focus on societal differences and bring the topics of mental health and gender difference into the mainstream. Examples include *Compass, Series 33: The Common Thread, You Can't Ask That, Series 2&3, Please Like Me, How 'Mad' Are You?* and *Nanette*. These programs reduce stigma, but perhaps unintentionally may romanticise certain conditions (and invite copying or self-diagnosis).

The definition of sexual identity and the consolidation of personality are gradual and fluid processes, especially in the second and third decades of life.

Social media, of course, are not vetted for accuracy and are unfiltered, so 'truth' is difficult to establish.

During the social restrictions of the pandemic, there has perhaps been a greater tendency for individuals, as they construct their online identities, to be influenced by poignant, dramatic or heroic media representations of personalities or disorders. It is therefore important to have wide exposure to different programs and points of view to maintain perspective.

Social advocacy groups increasingly promote public awareness of mental health issues and of specific conditions.



Image Credits: Anonymous Student.

May 2022 was Mental Health Awareness month October 2022 will be both Domestic Violence Awareness month and Bullying Prevention month.

When Life does a number on You

The medical profession, including medical students, is expected to be fully functional in order to properly care for society. I found Medicine to be engaging, fascinating and deeply rewarding.

It's also a tough gig. Five decades ago Medicine was mostly regarded as all-wise and all-knowing and as a service profession – as a calling or vocation. Currently, fewer people automatically view doctors as altruistic. Patients are less trusting, quite rightly expect to be consulted about their medical management and often use ratings to inform their choice of docs, especially specialists.

Despite those changes, in Australia, doctors are currently voted as the 'most trusted profession'

When life serves up difficulties, as it sometimes does, it's easy to deny what's happening or to feel uncertain about actively seeking a solution. The risk of suicide is higher in the medical profession.

A most important thing you can do as a medical student to protect your own equilibrium is to form a good, ongoing relationship with a GP that you trust so that you have a reliable outside perspective as well as good ongoing health care

SA is fortunate to have an organisation, **DHSA (Doctors' Health SA)** which is dedicated to the support of doctors and medical students and has a special focus on the support of Rural Docs.

When you think about it, having a medical student as a patient is not straightforward for a GP, so DHSA has a list of GP's who have expressed their willingness to accept medical students and have undergone additional training. DHSA plans to hold an Australasian Doctors' Health Conference here in Adelaide in December 2022.

Please check their link - there are many wonderful support services:
<http://doctorshealthsa.com.au/about-us>

The Flinders University Health, Counselling and Disability Service, with GPs and counsellors, is on campus nearby (08 82012118).



Susan O'Brien, MBBS

1. Hopkins Press. 2021. DSM: A History of Psychiatry's Bible [Online]. John Hopkins University Press. Available: <https://www.press.jhu.edu/newsroom/dsm-history-psychiatrys-bible>



MUSLIM MEDICAL PROFESSIONALS IN AUSTRALIA

'Whoever saves a life, it is as though he has saved the lives of all mankind'

Quran: Surah 5, Verse 32

Australia is home to an ever-increasing cultural and religious diversity. The healthcare profession has to be responsive to these changes, as research indicates cultural competence can directly influence the quality of healthcare outcomes and risk [1].

Islam is the second most practised religion in Australia, followers of this faith are known as Muslims. According to the 2021 census, we have approximately 814,000 Muslims in Australia.

Though there is individual variation to how Islamic principles are practiced, its ethos comprises a code of life that affects its adherents' decisions in everyday life, including healthcare. As a result, there are several scenarios in healthcare where religious consideration is a must. Some examples include medications like Ventolin and insulin during Ramadhan (Fasting), optional abortion, end-of-life matters, post-op implications of urinary tract surgery and the keeping ritual purity (ablution) [2].

However, Muslim patients are not 'special' in that they require extra attention. Indeed, life is sacred within Islam, and the preservation of life overrides all guidelines, rules, and restrictions. In life-threatening

situations there are exceptions to Islamic rules. Islamic philosophy is that all events in one's life are the will of God, as a result Muslim patients may display better acceptance and compliance with their healthcare needs [3].

In Australia, there are a substantial number of Muslim doctors, the Australian Islamic Medical Association (AIMA) is an organisation that represents Muslim healthcare professionals within Australia



In the past 4 years since its inception AIMA has led several initiatives/campaigns in Australia including the blood donation drive, a program to bring blood donation programs to mosques, CPR workshops, mental health and diabetes awareness programs, and mentoring support for medical students. Overseas AIMA has conducted several workshops and camps in underprivileged regions to provide medical services free of charge, including a urology and a general surgery camp in Pakistan and vesicovaginal fistula repair in Tanzania.



Interview with Dr. Muhammad Kahloon

Placebo conducted an interview with Dr. Kahloon, the President of AIMA to shine a light on the work and contributions of Muslim medical professionals in Australia

What is AIMA and what prompted/ inspired the idea for AIMA to come about?

AIMA is the Australian Islamic Medical Association, which started out in Canberra, about 4 years ago. Our values are to inspire, unite, and serve. To unite Muslim medical professionals, inspire the medical Islamic community, serve the community, and provide a platform for the organised activities of Islamic healthcare.

When you do things individually it goes unnoticed, but when you partake in organised activities then seeing is believing.

Over the past several years, Muslims have been portrayed in a negative light and there has been a lot of negative publicity. By running these programs, we wish to show what Muslims are truly like because we are contributors and not just consumers, we are an asset to this society, not a liability.

What kind of impact has AIMA's work had on the community, and the perception of Muslims in Australia?

Running various campaigns has created a lot of good will. The blood donation drive programme which has been running for the last 3-4 year started at just one mosque, but it has now spread to 43 mosques across Australia. The Australian Red Cross recognized the positive impact of this work and presented us with a special award last year.

We also received a lot of emails from everyday Australians about how seeing AIMA's work has led them to reconsider their opinions about Muslims and Islam. Though a lot more work still needs to be done, this is a small step in the right direction.

What have been some of the biggest challenges you came across during your work with AIMA?

The biggest strength of AIMA is its members. However, the biggest limitation is also its the members because they are juggling competing work and family commitments and there are only a limited number of hours in the day. It is sometimes a challenge to convince people that this initiative and cause is worth their commitment and their time.

We are slowly growing over time and now we have footprints in every state and territory.

Does AIMA have avenues for medical students to get involved?

Our medical student friends and allies can absolutely contribute. We run workshops to teach CPR in mosques that they can join, we also run workshops educating the community about mental health and diabetes awareness. You can join as an associate member of AIMA as a medical student, and we do encourage medical students to join.

The scale of the work you can do with the tools and technology you have as medical students is much more than what our generation had.

This is of course a two-way exchange, and on our end, we are developing a mentoring program for medical students which will focus on providing them with tools that they can use for their career, research, and speciality training. We have a pilot programme in Sydney that we would like to expand to other states. If students in SA think this is a good idea, we welcome them to come together and approach us, our email is on the website, and we will arrange a similar mentorship scheme.





What is or what can AIMA do to put Muslim medical professionals at the forefront of healthcare?

We are there but we are invisible.

We are there but we are not being appreciated.

We are there but we are not being registered.

This is why it is critical to have a platform to run organised activities that reach out to the wider community, as well as your own colleagues. As I mentioned earlier, we receive emails from all parts of society complimenting AIMA's efforts and identifying how AIMA has helped them to change their opinions about Muslims. Our difference can be more tangible when it is an organised effort, and that is being noticed by individuals from our community.

I know that to many Muslim doctors, faith and medicine are very intertwined, for you how does how does faith govern the way you practice medicine?

I think Islamic ethics are not that different from the ethics the wider society demands from us. I make sure I adhere to these ethics, the benchmark for me is to provide the level of care that I would to my own brother or my sister. If religion impacts me in any way, it is to make me hypervigilant.

Do you think it is important to have education regarding the care of Muslim patients for doctors in Australia? Diet, modesty, gender segregation etc.

As a rule, when your patient enters the consultation room a doctor must create a relationship of trust. *Your patient should feel that the doctor is sensitive to their beliefs, faith and values.* So, this education is very important on both an institutional level and on an individual level. AIMA can play a role in this regard, as it continues to grow it can approach institutions and act to provide education about sensitivities particular to Muslim patients.

What advice or words of wisdom do you have for current medical students that want to have a positive impact on the world?

I have two daughters that are in medical school. I will give you the same advice that I gave to them. I think awareness is very important; awareness about what is happening with you, with the world around you, about where you stand and the challenges you face. When you have such awareness, then things will not come to you as a shock, because with awareness comes preparation. But at the same time balance is important, Though you need to be aware and participate in different initiatives, your time and duty now is towards your studies. So, equip yourself with the knowledge, with the grades and with publications and progress in your career so you reach a point where your words and actions carry weight and make a big difference.

If you had the opportunity to make a supplication that you knew would be accepted, what would that be?

I wish that this world becomes a place where human beings are judged by their work, not judged by their colour, gender or religion. A world free of injustice and prosecution, and a world based on justice and peace.

*Images kindly provided by the Australian Islamic Medical Association.
Interview conducted by Noreen Khan.*

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Australian Islamic Medical Association

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Image Credits: Rakad Alghizzi.

A MEDICAL PERSPECTIVE ON EFFECTIVE ALTRUISM

'A Medical Perspective on Effective Altruism' 'Effective altruism' as a philosophical and social movement has spread slowly around the developed world since the 2000s. This movement has touched the lives of millions of the most underprivileged and impoverished people on earth, yet by all its merits still avoids catching the eye of governments, companies, and the average taxpayer. Doctors shoulder a moral burden as leaders in society, and that is an opportunity for us to lead not only with our expertise, but also with empathy and reason both locally and globally, to improve the health of those less fortunate. I believe this can be achieved through the ideals of Effective Altruism.

The most basic interpretation of Effective Altruism is 'How can good be done the most efficiently' [1]. Melbourne-born philosopher and current Professor of Bioethics at Princeton University Professor

Peter Singer is the author of 'The Life You 'Can Save', a notable piece on Effective Altruism. In it the core premise he implores us to consider is this:

'A life is a life no matter where that life lives. A human being over there is no less valuable than a human being over here.' Which he follows with a series of introspective questions:

'What am I doing as a human being on planet Earth to help the less fortunate?'
'Can I perhaps do a little bit more?'
'If so, how?' [2]

The answer, unsurprisingly, is in Effective Altruism.

According to the World Bank, there are currently ~700 million people in extreme poverty (living on less than \$2.75 per day). What is this like?



Image Credits: Rakad Alghizzi.

'You are short of food for all or part of the year, only eating one meal per day, often having to choose between stilling your child's hunger or your own and sometimes being able to do neither; You can't save money, when your child falls ill you can easily be trapped in crippling debts to moneylenders with high interest rates seeking a remedy, and medical care often requires days of travel by foot; You can't afford to send your kids to school, or they have to be taken out if the harvest is poor; You live in an unstable house you have to replace after every few years or if the weather is severe; and you have no nearby source of safe drinking water' [2].

Objectively reading the above description we know that one living in such circumstances is in a place of constant struggle and suffering just to keep themselves and their children alive. Sadly, this struggle often ends in failure and death [2]. But what can we do? In Australia we sit comfortably in peace and prosperity with money and time to burn on our leisure, we are so far removed from these people and their plight. What if you could be convinced that perhaps just some of that extra time and money could be devoted to alleviating their hardship, illness and suffering? Perhaps even less than you would suspect.

For \$970 you can give a young woman her life back through Fistula Foundation, for \$35 you can cure blindness through The Fred Hollows Foundation, and for as little as \$2.80 you can prevent malaria in 2 people for 3 years through the Against Malaria Foundation. The benefit of organisations such as The Life You Can Save and Givewell is that they take the guess work out of it, you can be confident that the charities they recommend are doing high yield impactful work with transparency, teams of researchers have elucidated this for each recommended charity.

Effective Altruism does not encourage you to donate all your money and earthly belongings to achieve its ideal. Depending on your income, Singer has proposed a sliding scale encouraging taxpayers to donate as little as 1% of annual income, which would firmly close the poverty gap with negligible impact to donor quality of life [2].

The impact of adhering to the ideals of Effective Altruism financially should not be underestimated. It is relevant for every taxpayer but arguably more for those with greater affluence. As medical professionals we are in a privileged position where we can contribute to these causes not only with our future affluence financially, but also with our time using the skills and expertise given to us in our training.

Médecins Sans Frontières (Doctors without Borders) is the leading humanitarian organisation providing medical services on the frontline of extreme poverty and humanitarian crises. MSF provides Doctors opportunities to work in environments where medical care is often absent or lacking expertise, where medical interventions can have the ability to save lives, improve health outcomes and increase the wellbeing of whole communities and societies [3]. Doctors who have done work for MSF often report the liberation of being able to practice 'pure' clinical medicine, making diagnoses and choosing interventions with limited resources as well as needing to endure less bureaucracy and non-clinical obligations.

Dr Claire Fotheringham, a medical advisor for obstetrics and gynaecology with MSF, shed light on the impact a medical professional working with MSF can have. A primary focus of MSF is to build the capacity of fragile and fledgling health systems through collaboration and education, with the aim of developing the

independence of those health systems in the long term. Doctors play a vital role not only in providing lifesaving and disability alleviating healthcare, but also in educating the local health professionals around them.

MSF delivers its programs collaboratively with local health systems and advocates for the countries they are active in. This has substantial ripple effects on the health and wellbeing outcomes for millions of people not just those whom health professionals interact with directly [4]. Additional to its role in advocacy, there is opportunity to conduct clinical research and help develop treatments and protocols unique to humanitarian contexts [5]. The contribution that can be made as a doctor working for a humanitarian organisation such as MSF aligns strongly with the ideals of Effective Altruism.

As alluded to, there are other ways in which doctors can adhere to the ideals of Effective Altruism using their time. Medical research in the modern era has substantially progressed the life expectancy and quality of life for people the world over, pursuing a career including research will contribute to this trajectory [6]. Consider the development of the smallpox vaccine – this breakthrough in medical research can certainly be attributed to the prevention of millions of deaths, not to mention the emotional turmoil and societal consequences associated with the disability survivors experienced [7]. It is therefore pertinent to consider what research is worth pursuing in our modern context.

Since first being introduced to Effective Altruism I have felt a renewed sense of purpose in the direction I intend to take my career. I believe this can be the same for anyone, regardless of their profession or specialty. Adhering to the ideals of Effective

Altruism has the potential to give you the ability to have impact far beyond what you may previously have believed possible. I implore you to consider how you conduct your future professional lives as doctors and encourage you to seek an understanding of how you can conduct yourself in a way that is of both providing immense benefit to those less fortunate while being highly fulfilling for you. Perhaps you will find that they come in tandem.

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**Tom Cliffe
MD1**

Interested in the full-length article?

Follow this QR code for more information on the topic of Effective Altruism from Tom Cliffe.

SCAN ME





A word from the author...

Visit [The Life You Can Save - Best Charities for Effective Giving](#) for more examples of how little it can take to have a significant and traceable impact on the lives of the less fortunate, which each in their own way has potential to have long lasting flow on effects to the rest of those communities and societies, with eventual global repercussions. If you would like more information about Effective Altruism, please see the following resources:

Peter Singer: The why and how of effective altruism TED

A good introduction to Effective Altruism including some of Singer's strong philosophical and logical arguments, as well as methods to begin contributing.

Everyday Emergency: a podcast from Doctors without Borders (MSF).

Listen to some of the inspirational stories from the health workers on the frontline of MSFs programs, free wherever you get your podcasts.

The Life You Can Save: Best Charities for Effective Giving

Scroll through The Life You Can Save's list of best charities and learn about the variety of impacts achieved by these organisations.

The Life You Can Save by Peter Singer (podcast)

A podcast version of The Life You Can Save which can be listened to in just over 7 hrs. Free wherever you get your podcasts

Effective Altruism Medicine: Investing Your Time & High Impact Medicine

Websites for medical students and doctors who have an interest in Effective Altruism. They discuss further the role doctors have in research, advocacy and public policy which can align well with effective altruism. They also give insight into the perspectives and experiences of doctors who adhere to Effective Altruism in their professional lives.

CADAVER

The red nail polish shocked me. It was as abrupt as the anatomy lab smell, reaching into the pit of my stomach. I had spent ten minutes feeling apprehensive, staring at the plastic sleeve on the trolley cover containing the dissection manual and listing a body number. Standing at her feet when they pulled the cover down, my eyes were drawn to her hands curled stiffly on the stainless steel.

I was rigid as they removed the cloth from her face and torso, accidentally exposing her pubic region, which a male student promptly tucked beneath blue plastic for modesty. Leaking tears behind my mask, I imagined her applying that polish before she died. Or perhaps someone did it for her. I noticed age spots strewn along her thin, elegant arms. Noticed that, like me, she didn't shave her armpits, but let the hair grow long - this struck me as exceedingly feminine. She was relatable.

I edged closer, wanting to see her properly before she was inexpertly disfigured by scalpel blades. Her skin was smooth from the formalin, mottled and pale in patches, belly-button smudged off-centre and breasts sagging toward the anterior axillary lines. Anatomical terms felt foreign and disjointed to me. They were of no comfort. My eyes, now obnoxiously damp, grazed the hole where they introduced the embalming fluid, and finally strayed past her neck to her face.

Chin tilted upwards, her mouth gently parted as though she was about to receive a kiss. Her bottom lip was sagging under so I could see her gums and a dark rotten tooth, which must have been painful at one time. A gentle fuzz covered her upper lip, which I noticed was slightly longer than the hair on her scalp where they'd shaved it to the skin. The image of a concentration camp reinforced itself in my mind when I remembered the 5-digit number identifying her body, which I'd spent so long scrutinising.

Her eyelids, like her mouth, were gently parted, with eyeballs sunken and retracting. People say the eyes are a window to the soul, but hers were so dull and dry and shadowed that they hardly bothered me as much as her hands. They certainly said much less. It seems, in death, our eyes are lost and our body does the talking.

By now, the other students had made the first cut, second cut, made mistakes, pierced the skin as they tried to peel it away with the scalpel. I felt a surge of emotion, overwhelmingly protective of this woman. I'll never know her name, or why in the days before her passing she had prepared her fingernails to haunt me. But she's my teacher now, and this is her first lesson: a body is something deeply personal. It is not a tool to be treated dispassionately. Not a bag of flesh or a jigsaw of pieces crammed together under strips of fascia and adipose.

It is a layered piece of art, intricate and unique. I want this woman to be made present in every cut, every rip, every unfolding. I hope we acknowledge that she is teaching us, and that her family has likely made a great sacrifice for her to do so. If not, I know her hands will be there cupping the air, patient and insistent, saying, I painted my nails so you would not forget me. But perhaps she thought none of this - maybe she wasn't attached to her body, or protective of it like I am of mine. In any case, I will take good care of her. Because dignity is a thing deserved, even in death. And this is more than an anatomy lesson. This is more than a box to tick. We are confronting the depth of a human body, and I am so glad that it shocked me.

Jaida Buck
MD1

ATTENTION DEFICIT HYPERACTIVITY DISORDER

A FEMALE PERSPECTIVE

When you think of ADHD, you think of a hyperactive pre-pubescent boy, right? That's what I thought of too, until two years ago when I had just finished my first semester of med school.

I was chatting with an acquaintance one day about my uni struggles when out of the blue, she said "Some of the things you said you struggled with are common in people with ADHD, why don't you do this quiz to see if you might have it?" I took the quiz to humour her, thinking no way - but then my jaw dropped when my results were highly suggestive of ADHD.

In what I now know is called hyperfocus, I researched ADHD and particularly how it manifests in women, quickly realising I didn't know the first thing about it. The more I read, the more I felt like I'd found the answer to a question I didn't know I had.

Reading stories about daydreaming in class, making silly mistakes, being a perfectionist, fidgeting, feeling anxious and worried that I hadn't achieved my potential - I felt understood. ADHD was so different to the bouncing off the walls stereotype I had in my mind.



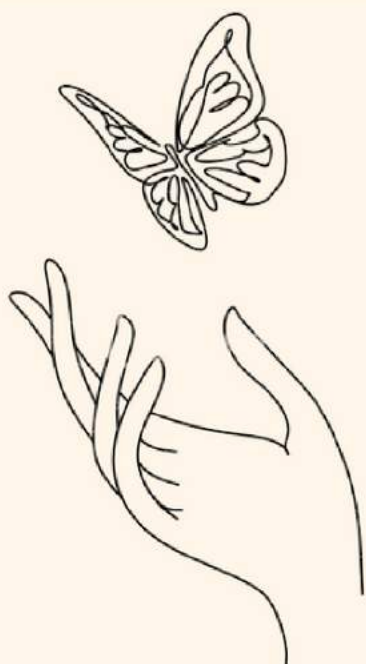
According to the DSM-V, ADHD is a neurodevelopmental disorder that is characterised by a persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development. More simply put, ADHD affects the brain's executive functioning - the cognitive processes and behaviours we need to work towards our goals. Impaired executive function can appear as disorganisation, procrastination, inattention, distractibility, impulsivity and forgetfulness. These symptoms are experienced by many people, but when the severity of these symptoms interferes with or reduces the quality of a person's social, academic, or occupational functioning - that could be ADHD.

Many children with ADHD are diagnosed soon after they start school, when symptoms like fidgeting and forgetfulness become more obvious. For some people, ADHD impairments may not be noticeable

until adolescence or even adulthood as the demands on a person's executive control increase. ADHD Australia estimates that 1 in 20 Australians has ADHD, but that up to 75% of people with ADHD are not yet diagnosed. Extrapolating these estimates, the struggles of millions of people in the world with ADHD are either discounted or misattributed to other conditions.

This discounting or misattribution is particularly true for women who have ADHD. ADHD doesn't gender-discriminate, but the assessment of ADHD does. There is a prevailing thought that females don't get ADHD – even by some psychiatrists – as they are more likely to mask symptoms. The impairments from undiagnosed ADHD are more likely to be misattributed to anxiety, depression or personality disorders in women, particularly as they are more predisposed than men to many of these conditions.

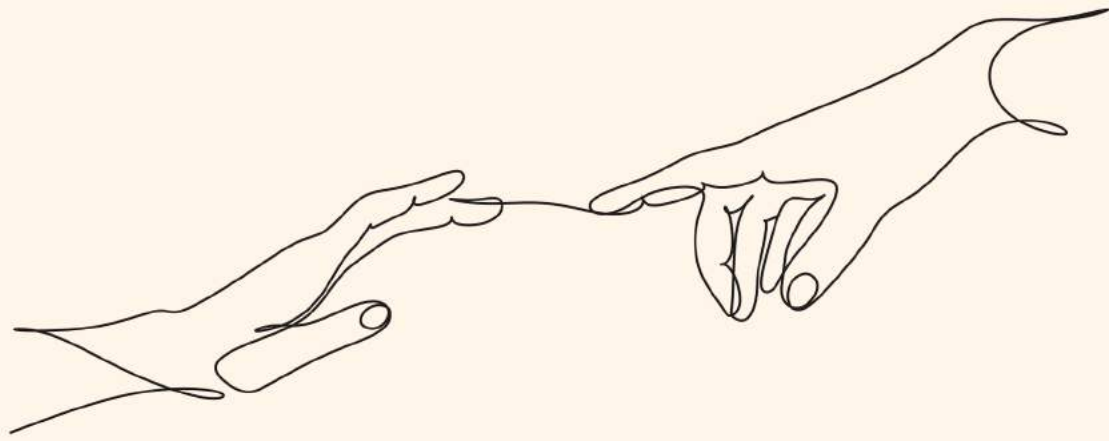
Sex bias favouring male over female research subjects exists across many medical studies. A prominent example is the Baltimore Longitudinal Study of Aging, which started in 1958 but effectively ignored half the population for its first twenty years by excluding female participants until 1978.



This phenomenon of excluding female participants from research also affects the diagnosis of ADHD. Many screening tools for ADHD are skewed towards the hyperactive presentation, which is more common in boys, than the inattentive presentation which girls are more likely to have. In a busy classroom, do you think the child fidgeting and distracting their peers or the child quietly daydreaming would be more likely to get an ADHD diagnosis?

With these things considered, ADHD is likely underdiagnosed in women and should not be dismissed as a 'trendy' diagnosis. Those who pursue a diagnosis may encounter psychiatrists who do not understand how ADHD manifests differently in women and assess them using screening tools that aren't cognisant of these differences. They may even be unfortunate enough to find a psychiatrist who doesn't believe that ADHD is a legitimate diagnosis in women, and just label them as anxious. I myself was diagnosed with anxiety 10 years ago, but since starting treatment for my ADHD my anxiety has significantly lessened as I'm not constantly overwhelmed.

The pressure on women to "have it all" and to never being seen as less than perfect



often results in chronic overwhelm and exhaustion for many women with ADHD. It is quite common for women to be diagnosed once they become mothers and the demands on their executive function increase (and sleep decreases). In retrospect, the compounding effect of postnatal depression after having my first child on my then-undiagnosed ADHD is when my executive functioning became noticeably impaired. When I added medical school (and another child) to the mix, the coping mechanisms I had unknowingly developed were not enough to offset my impaired executive functioning and my symptoms became obvious.

Leaving school, I had the marks to study medicine but I didn't have the confidence (or study skills). I took a circuitous route through study, jobs and motherhood to arrive back at medicine and pursue my dream of becoming a doctor. I loved learning the ins and outs of medicine but I was struggling – not with the concepts I was learning, but with the art of studying. I have always been prone to procrastination and when I finally gathered momentum in studying, any distraction would send me back to square one. I'd spend hours trying to study and would get little done. I had to write copious pages of notes during lectures otherwise I'd immediately forget what I was thinking about - a sign of my unreliable working memory.

It was at this point that I had that fateful conversation with my acquaintance, who opened my eyes to female ADHD. I had long wondered why I struggled with so many things that others did with ease. I would get side-tracked doing trivial things at the expense of more important things, leaving them to the last minute. I was perpetually restless and did not know how to relax. Quietly hopeful that this was the answer, I booked an assessment with a psychiatrist with a special interest in ADHD in women. Going into my assessment, I was scared that I'd be told I was being ridiculous. Instead, I was so taken aback by the psychiatrist taking me seriously that when they handed me a script of medication to trial, I asked "so I really do have ADHD?", they responded with "Well, it's a clinical diagnosis, but if things quieten down when you take these then that's confirmation the diagnosis is correct."

The next day I took my medication for the first time and it was so ... quiet. The constant internal noise in my head just wasn't there. I methodically did some housework for a while and even contemplated a nap, a sign of the paradoxical affect of stimulants on an ADHD mind. These "study drugs" didn't make me power through textbooks and lectures in a crazed state - they slowed down my thoughts enough so that I could process them instead of losing them in the

sensory overload I usually experienced.

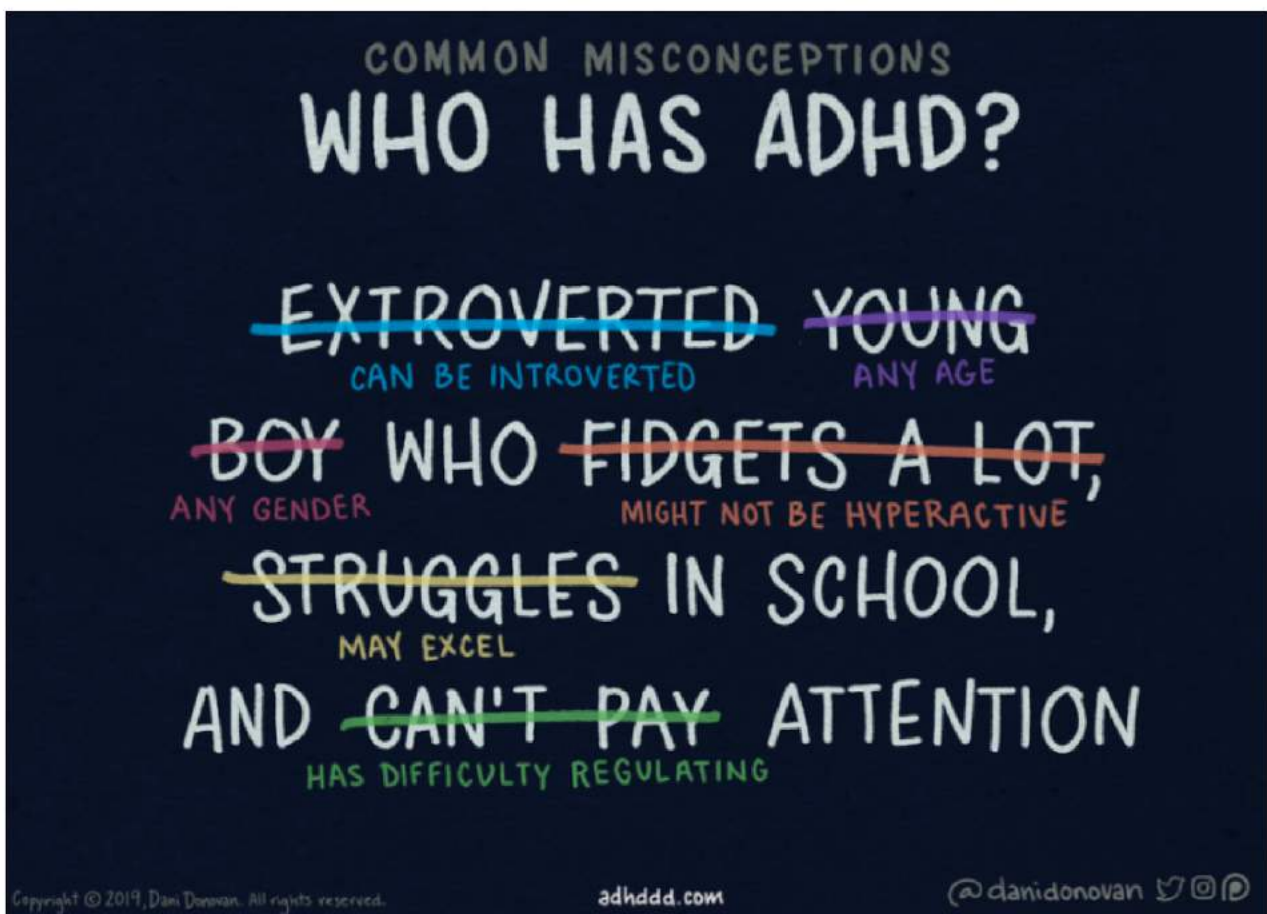
With diagnosis has come self-acceptance. Rather than trying to force myself to study in a way that doesn't work for me and berating myself when I fall short, I've allowed myself some grace and have adapted to methods of doing things that work for me. Rather than trying to read a dry textbook, I'll pick a topic that sounds interesting to me and do a deep dive, following the rabbit holes and learning through this process. The benefits of my change in study style were apparent when I made it through second year without failing anything (that counted – we won't mention the iRATs!).

ADHD is so much more than hyperactive nine-year-old boys, distraction and fidgeting and I can't possibly cover it all here. For those who are interested to explore more, please check out the resources on the following page.

♀ *Author note: I write from my perspective as a cisgender female who was diagnosed with ADHD as an adult. While I refer to the gender binary in this article for simplicity, I acknowledge that represents just part of the broad spectrum of gender identity.*

Shannon Waters
MD3

Mental health comics kindly provided by
Dani Donovan (adhddd.com)



Want to know more about ADHD in females? Here are some more resources from Shannon Waters:

- Dani Donovan (adhddd.com) – who gave her permission to use her on-point comics in this article
- ADHD Alien (<http://adhd-alien.com/>) - quirky and relatable
- How to ADHD by Jess McCabe (<https://howtoadhd.com/>) – like it says!
- Under the Sea ADHD Parody by the Holderness Family on YouTube
- ADHD Australia - <https://www.adhdaustralia.org.au/about-adhd/>
- The NHS page on ADHD is very accessible - <https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/>
- Gender bias in medical trials - <https://www.theguardian.com/lifeandstyle/2019/nov/13/the-female-problem-male-bias-in-medical-trials>
- ADDitude Mag has plenty of information - <https://www.additudemag.com/adhd-in-women-girls-symptoms-diagnosis-recommendations/>
- The diagnostic criteria for ADHD and screening tools to aid in diagnosing ADHD in adults - <https://www.qandadhd.com/diagnostic-criteria>



- The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist - <https://add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf>
- Sex differences in predicting ADHD clinical diagnosis and pharmacological treatment - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6445815/>





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THE CONFLICT OF TRUTH-TELLING IN HEALTH CARE

Breaking the bad news to patients might be doctors' worst nightmares and overly difficult, and contrary to popular belief, many doctors reject the idea of assessing the period a patient has left to live.

In many ways, informing the patient of the time they got left is part of a doctor's role and is important to do so as it allows the patient to prepare and do what's most important to them.

However, a conflict of the minds was raised when a patient who's been living with a terminal illness for a while died shortly after being told that he had four hours to live.

"It is shocking and not right, you cannot tell someone they have less than a day to live and they would be ok with it," says Sarah, the patient's family member.

The family mourning the death of their beloved family member says the patient constantly expressed his fear of death and has always hated living in the hospital for long periods as it reminds him that illness and death are around every corner and any minute his life could end.

"You cannot tell someone they have less than a day to live and they would be ok with it"

The patient's family and friends expressed their rage towards the doctor for telling the patient that he will be passing away sooner than he was expecting, they argued that the doctor could have told them before informing the patient.

"It makes me angry and disappointed that I was not with him the moment he passed away... It is a difficult thing to get over someone's death but to not be with them during their last breath when you knew they are afraid of dying is the most difficult thing."

"I don't believe he passed away because of the illness, I think he passed away because of the knowledge that he will be facing death in the face," said Sarah.

In a second thought, what would happen if the ambiguity surrounding our own death is revealed and the exact date and time was shown to each one of us? While this is impossible to know, it brings our thoughts

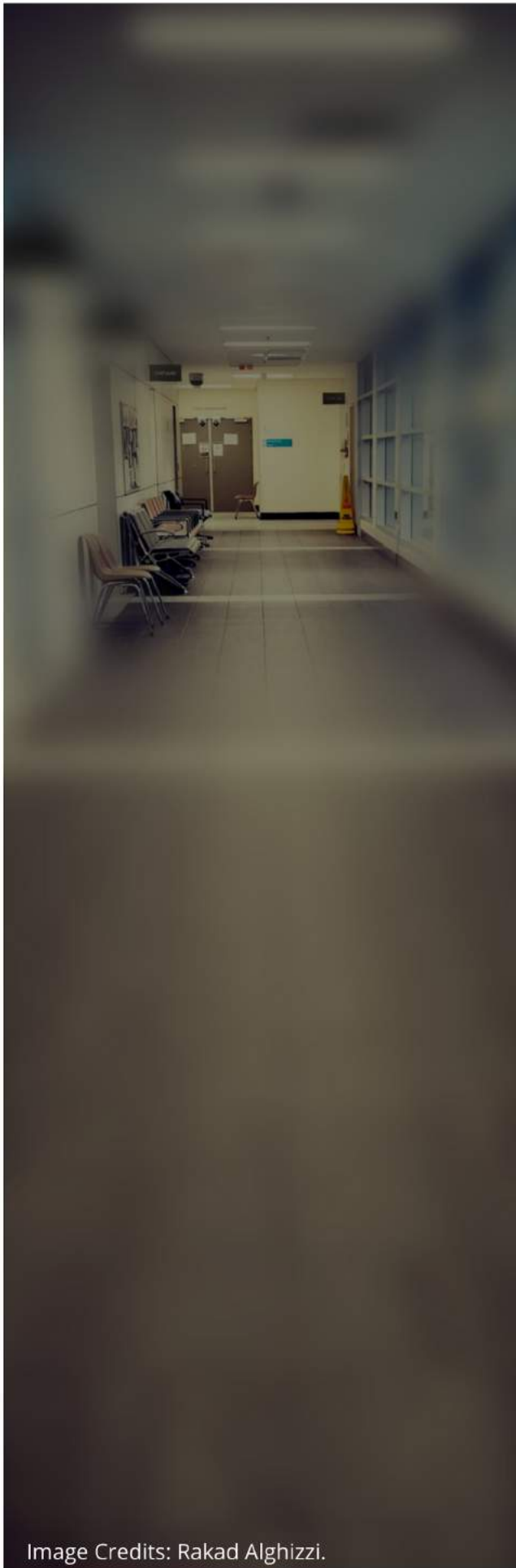


Image Credits: Rakad Alghizzi.

and feelings to the way how patients who know their demise face the reality of their nearing end.

Although, knowing one's own demise help in hinting at how best to spend the limited time one has got, the feelings of overwhelming anxiety, dread and terror of losing the chance to live might increase the risk of early death according to a recent study conducted [1].

The study found that those who died at earlier age had lower levels of the RE-1 Silencing Transcript protein which is responsible for quietening the brain from overthinking.

The thought of death also triggers mental health issues such as depression and anxiety causing other health problems and diseases and may trigger Thanatophobia, meaning an extreme fear of death or the dying process [2].

While another study shows that when thinking of death, people tend to cling to the institutions they are part of and the worldview they hold and tend to push thought of death away by distracting oneself [3].

However, conscious thoughts of death [4] increase health intentions and changes people's attitudes and behaviours for the better.

In the case of the patient's family and friends' anger towards the doctor, it is the thought and the value of the knowledge held in the words that they were afraid would trigger the patient's terror of death.

Although the family of the deceased accepted his forthcoming end, they wished that it would have ensued naturally and without the interference of fear and anxiety.

Nonetheless, it has yet to be proven whether the death was caused due to illness or anxiety, while bearing in mind that the patient suffered terminal illness and his body and mind may have sought after the peace and analgesia that would come after passing.

The ethics of truth-telling in health care settings is important to foster trust and be able to display respect to the patient. Patients place their trust in their doctors and may feel the trust has been misplaced if they perceive a lack of honesty in their dwindling health.

A study has shown that over the years, doctors regard truth to conceal or reveal in as it impacts the therapeutic welfare of the patient [5].

For an instance, a doctor might feel hesitant to disclose the deteriorating health of a vulnerable patient if the truth has the potential to harm, unsettle or depress the patient.

While this approach sounds logical to many, it conflicts with the principle of autonomy and informed consent. Therefore, this approach has been set aside due to the growth of society and the evolution of law and consent.

Moreover, most patients prefer the truth concerning their diagnosis to be informed participants in important health care decisions concerning their health [5].

Overall, the only way that truth can be concealed from a patient for some time is if the patient's doctor has compelling evidence that the information may cause harm to the patient [6] or if the patient has physically informed or written an informed statement not to be told the truth [7] or to reveal said truth to family members instead [6].

Open communication can also be an option in communicating with the patient in whether they wish to know about the bad news of their dwindling health. However, a study shows this option may cause the patient apprehension and anxiety as if knowing the cause.

The conflicting approach of death by medical practitioners is broad, however, as clients and patients, one must remember that medical practitioner are as affected as the patient's family and friends.

Rakad Alghizzi
Freelance Journalist and photographer

Disclaimer: suggestions mentioned in the article are for general information purposes only.

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RESPOND RESCUE GENERAL P1

“Respond Rescue General P1”, these words scrolling across the pager indicate that something seriously wrong has happened. From general to specialist rescue, any P1 indicates that there is a threat to life, and the goal of anyone responding to a P1 is to save the maximum amount of lives in the shortest amount of time. This defining goal of the South Australian State Emergency Service (SASES) is no better visible than in the way that we approach first aid.

SASES is the controlling emergency service for severe weather and flooding. Additional to these responsibilities, SASES is involved in rescue operations. The type of rescue varies, but can broadly be broken down into two; specialist rescue, which revolves around extracting casualties from complex situations (vertical rescue, swift water rescue, road crash rescue, urban search and rescue); and general rescue, which revolves around extracting casualties from less complex situations (cyclist accidents, broken legs from hiking, spinal injuries on elevated platforms). Both types of rescues require the conscious effective application of teamwork, first aid, and casualty management.

Working together is a core capability of any team. Working in a team with the pressure of someone’s life in you, and your team’s hands is a more select skillset. The key thing that I have learnt throughout my time in the SES is that a calm and collected team member is the ideal team member. No matter the rescue, no matter the casualty, and no matter the intensity, being centred results in the best outcome for the casualty.

The key to developing this centred perspective regardless of situation is practice, and practice in an environment that is as true to life as possible. The SES provides this by having various training facilities across the state, capable of providing training in unique rescue scenarios. This high-fidelity training provides an excellent basis for SES crews to develop. This sort of training would also provide an effective tool for those studying in the College of Medicine and Public Health, to develop emergency management and teamwork in high pressure situations.



First aid in the context of emergency rescue is a highly complex topic. The variety of casualties that SES encounter are as varied as the injuries that can be sustained. The primary goal of any rescue first aider is to ensure that the casualty can safely be handed over to Paramedics. To this end the majority of first aid revolves around, stopping/slowing bleeding, slinging/ splinting injured limbs, and providing CPR. These core skills are always at the forefront of any rescue, and all training.

Outside of the general first aid provided by SES during a rescue, there is a second and ultimately far more important aspect of a first-aiders responsibility, which is casualty reassurance. Communicating with a casualty about what is happening to them, and what is being done to rescue them, is an absolute must of any rescue, and something all of those working with patients should be comfortable doing.

The South Australian State Emergency Service, facilitates the development of critical skills, revolving around rescues, teamwork, and first aid. These capabilities are constantly developed in high-fidelity environments to real life scenarios, these skills are also highly transferable to those working in or studying for a career in healthcare. If you'd like to learn more and volunteer with the SASES visit

<https://www.ses.sa.gov.au/home/>



Evan James Pargin
On behalf of South
Australian State
Emergency Service (SASES)

Photos courteously
provided by SASES





THE FLINDERS UNIVERSITY PAEDIATRIC SOCIETY

The Flinders University Paediatric Society (FUPS) is a relatively new student-run society at Flinders University. We aim to provide educational and networking opportunities for students interested in paediatric medicine, preparing them for work with children and adolescents. Regardless of whether our members will become paediatricians in future, all of us will need to treat children at some point during our training and future careers. We believe that fostering good communication skills with children and understanding their unique needs are necessary skills for all medical and allied health practitioners.

What is our society about?

- Creating a community for like-minded students interested in paediatrics
- Providing educational and skill-development opportunities for health and medical students passionate about paediatrics
- Improving awareness of issues impacting children's health
- Fundraising for not-for-profit foundations focused on supporting children's health and wellbeing

What are our plans for 2022?

This year, our committee has some great ideas about how we can expand and grow FUPS into a society that benefits the health and medical community through provision of educational events, fundraising and volunteering opportunities for our members.

Currently, we are in the process of establishing the 'Teddy Bear Hospital' program at Flinders University. This program was first established in 2009 at the University of Melbourne and provides a unique opportunity for health care students to teach children about experiences they might have when visiting the doctor and other health professionals. Student volunteers assist children at different stations, where they learn about various aspects of a health check-up, with their teddy bear as the patient. This opportunity allows children to improve their health literacy and build healthy habits, such as eating well and exercising, whilst in a fun environment. By exposing children to medical practices in a positive manner, we can ease any fear or anxiety they may have surrounding health care. Additionally, this is a valuable opportunity for our members to gain experience working with and educating children.



Later in the year, we aim to engage in fundraising opportunities. Stay tuned for the CanTeen National Bandanna day event and our Christmas donation drive for the Women's and Children's Hospital. Other events that we are very excited to host are our annual Paediatric Emergency Night in collaboration with the Critical Care Society, a Child Protection Education Night and a Children's Allergy Information Session!

We want to welcome all Flinders students to join our society and attend our events. We understand that paediatric health does not only concern doctors, but also nurses, occupational therapists, physiotherapists, audiologists, speech pathologists, dieticians and other allied-health professionals. Therefore, we are looking to expand our membership base beyond that of the medical student cohort!

Following our social media platforms is the best way to make sure you don't miss out on all the amazing events we plan to run! If you have any ideas, are interested in paediatrics, or want to find out more, do not hesitate to contact us via our Facebook and Instagram pages!

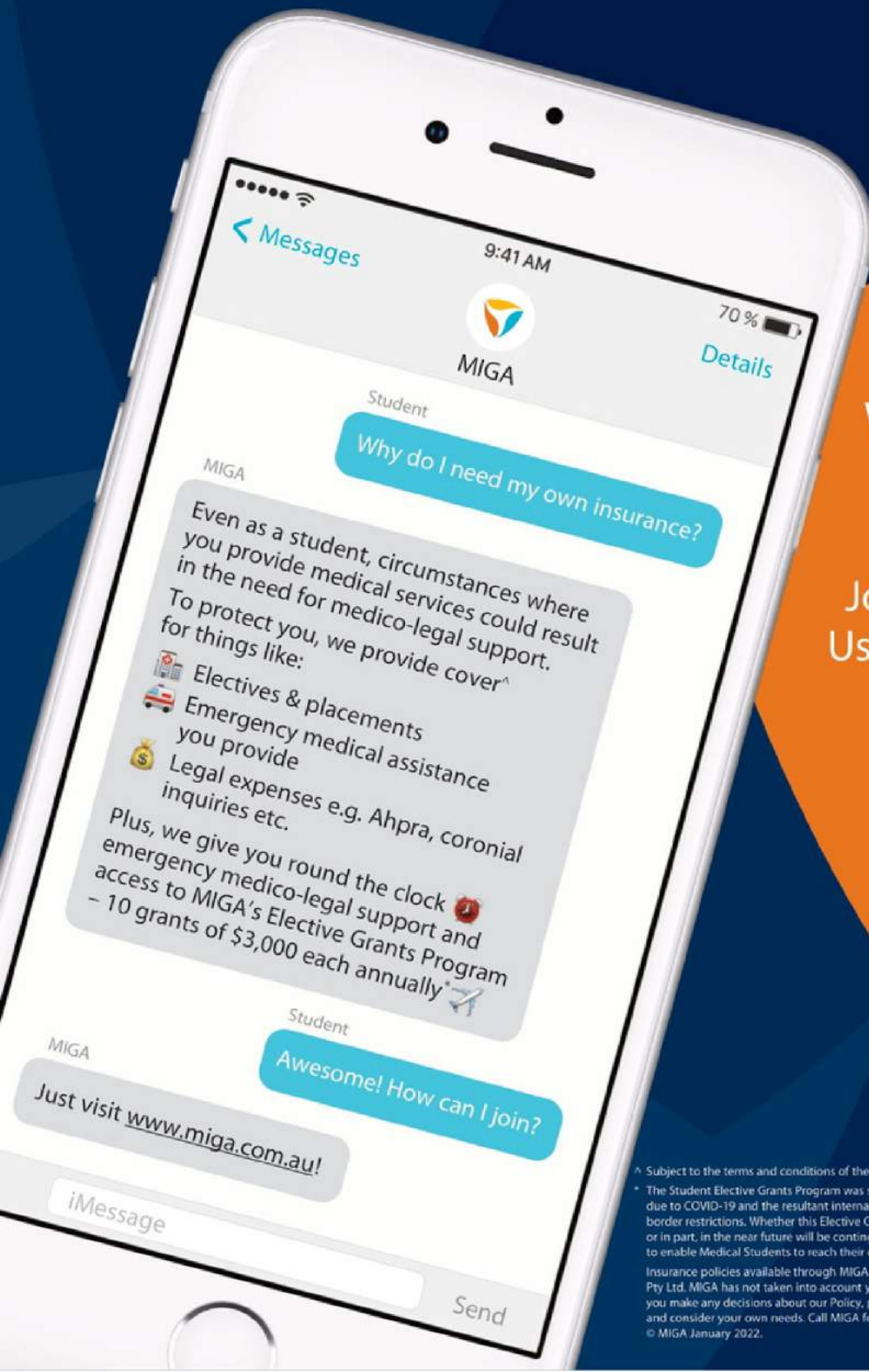
Yours Sincerely,

Naomi Gamage and Amy Booth

Flinders University Paediatric Society Co-Presidents



Protect yourself with FREE medical indemnity insurance for students



What are you waiting for?

Joining online is easy –
Use the QR code below!



^ Subject to the terms and conditions of the policy
* The Student Elective Grants Program was suspended during 2020 and 2021 due to COVID-19 and the resultant international travel and Australian State border restrictions. Whether this Elective Grants Program can be offered, in whole or in part, in the near future will be contingent on the easing of travel restrictions to enable Medical Students to reach their desired elective destinations.
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South Australian
Salaried Medical
Officers Association

JOIN NOW!



SASMOA is the **South Australian Salaried Medical Officers Association.**

Run by doctors, for doctors, SASMOA stands up for your rights in the workplace.

Start your career in public hospitals with the right advice, guidance and protection. **JOIN SASMOA.**



A MESSAGE FROM OUR PRESIDENT



Dr Laura Willington
President, SASMOA

At SASMOA we know the excitement, challenge and reward of a medical career. We also know from experience that you will be confronted, exhausted, and stressed. That not every day will go according to plan.

SASMOA is here to provide representation and support for you at work throughout your career and especially your first years as doctors. Our mission is to improve your working lives.

So far in 2022 SASMOA has won:

- Increased **job security** by lengthening minimum Trainee Medical Officer (TMO) contracts after internship from **1 year to 3 years**
- A requirement that SA Health must pay interns and TMOs for **all the hours they work** (believe it or not, this doesn't always happen)
- A **Respectful Behaviour** requirement to combat bullying and harassment against trainee doctors
- Orders that **rosters will be issued at least 28 days in advance** – so you can actually plan your lives

I welcome you to an incredible career and invite you to join us. Because together, we really are all stronger.

WE CARE ABOUT YOUR WELLBEING

Young doctors' own health and wellbeing are key SASMOA concerns.

That's why we are campaigning on a new **TMO Charter** which outlines the minimum standards needed to create a 'well workplace' for young doctors.

You can check it out online at sasmoa4doctors.com.au/tmo-charter

It's also why SASMOA actively supports initiatives to highlight and address wellbeing issues, like the annual '**Crazy Socks 4 Docs**' day on the first Friday in June every year.



@sasmoa4doctors

