PLACEBO

2023

ARTIST:
MYA DAMON

Flinders Medical Student Society (FMSS) acknowledges the land that we meet and study on as being the traditional lands of the Kaurna (SA) and Larrakia (NT) people since time immemorial and that sovereignty was never ceded.

We pay our respects to past, present and emerging Kaurna and Larrakia elders and extend that respect to all Aboriginal and Torres Strait Islander people today. We also acknowledge the traditional custodians of all other Nations where Flinders students study and live.

We wish to highlight that Aboriginal & Torres Strait Islander peoples were the first holders of Medical knowledge and still continue to practise these ancient ways of healing. We recognise that health and wellbeing, for Aboriginal & Torres Strait Islander peoples, constitutes many layers, encompassing various aspects of identity and self. We strive to support the intertwining of this Ancient knowledge with contemporary Western Medicine.

FMSS PUBLICATION

ORIGINAL DESIGN BY
MYA DAMON

CONTENTS

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A NOTE FROM THE ARTIST

My name is Mya, I am a Ballardong-Noongar artist with connections to Barngarla (Whyalla), Nawu (Tumby Bay) and Kaurna land. I have grown up in South Adelaide for the majority of my life and often incorporate and represent the landscapes into my artworks. I have recently completed my degree in Archaeology at Flinders University, although I have a passion for history, I have become very passionate about the visual arts and design - through my art I am able to connect with and continue my culture.

The artwork is representative of rural and remote health, I depicted this using specific colours that reflect the environment and local landscape. With this, I symbolised the use of health and education through handprints as a sign of connecting with one another - I also incorporated symbols of men, woman and children. Finally, I added plants to represent and signify the use of traditional medicines and knowledge.

Mya Damon, Contemporary and Indigenous Artist
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Thank you to the following people who provided advice regarding the display and use of Indigenous artwork:

Alison Hughes, Elder Liaison Officer
Dr Uncle Richard 'Balang/Japaljarri' Fejo, Larrakia Elder
Emma Vincent, Aboriginal and Torres Strait Islander Rep

WORDS FROM DR. UNCLE RICHARD FEJO ELDER ON CAMPUS

I am a Larrakia Elder and leader through my father and grandfather in what Aboriginal culture calls, "Grandfather lore" and I am also Wurramungu from my mother which is the Tennant Creeks region of central Australia. As of next year, I will have 30 years of experience in working across 40 urban, rural and remote communities throughout the Northern Territory to progress the well-being of Aboriginal people. I am Vice-President of the Darwin "Buffaloes" Football Club, a stand up comedian of seven years standing (boom, boom) and a singer/songwriter.

I am the Elder on Campus at Poche SA+NT, Flinders University in Darwin and mentor and support medical students from induction to graduation. I am also the Chairman of the Darwin Waterfront Corporation and oversee the strategic direction and the development of our masterplan while ensuring maintenance and high standards of the Darwin Waterfront land and water catchments. As the Chair of the Northern Territory Australia Day Council with board and staff support, we promote Australia Day events including hosting Seniors Week events, promoting nominations for awards in our community, receiving and progressing nominations across several categories and delivering events like the Australia Day Fun Run and The Australia Day Ute run plus several other events in between.

This year I joined the board of the National Disability Insurance Agency (NDIA) and the Australian Institute of Company Directors (AICD) Northern Territory Branch in 2023 while running my business, "Richard Fejo The Larrakia Man" performing Larrakia Welcome to Country and Saltwater Ceremonies in Darwin.

CAN YOU TELL US ABOUT AN IMPORTANT PLACE OR A PLACE YOU LIKE TO VISIT ON LARRAKIA COUNTRY?

My special place is Darwin as a Larrakia Traditional Owner I belong here where my Saltwater ancestors are all around me. Particularly, I like visiting the beach to reconnect with the ocean as a Saltwater Man and practice the Saltwater ceremony. The Saltwater ceremony is done by calling my ancestors in language and then placing my sweat into the ocean. As Saltwater People, our ancestors come from the land ands sea and the know my sweat so every time I see the ocean, I say hello to our old people/spiritual ancestors. Once I place my sweat into the ocean, their eyes open ad the see me again, then they guide and protect me on Country.

HOW DOES THE DREAMTIME INFLUENCE YOUR PEOPLE'S PERSPECTIVE OF HEALTH?

The Dreamtime is a central spiritual place that is the place where life comes from and the place that life returns to like an Aboriginal version of heaven for me. My uncle described it as the Alpha and the Omega, the beginning, and the end. A place where we come from and a place where we return so our spirit is not separate from our bodies and therefore just as important as our physical and mental well-being. If our spirit is unwell then our physical health and our mental health suffer as all are connected.

HOW DOES KINSHIP RELATE TO HEALTH?

Kinship is a definition of "kin" meaning family and through skin-names (Aboriginal names), we connect to our community whether blood related or not. An example in the kinship system is where my desert name is Japaljarri so if I were to meet another man on the bus today having never previously met him and he said he was called Japaljarri, then I would call him brother. Then is a lady was sitting next to him was his blood relation sister, then through kinship rules as he is my brother and she is also therefore my sister, then naturally I would also call her Napaljarri/sister. To be clear the word Japaljarri does not mean brother, my name Japaljarri belongs to a network called the kinship system and the word Japaljarri identifies me in my mother's language but where language change, so does the word.

In the northern regions of Australia including Darwin, my name is Balung and my sister's name is Ngal Balung but both are equivalent in relationship to the former.

The kinship system connects hundreds if not thousands of people to each other across so many regions and it acts as a system of governance as we learn and we teach. It is through this system we have many mothers, fathers, uncles, aunties, nephews and nieces and every relationship you can think of. Through family and through kinship, we maintain healthy and respectful relationships across our communities.

WHAT ARE SOME IMPORTANT LESSONS OR TEACHING POINTS THAT JUNIOR DOCTORS AND MEDICAL STUDENTS SHOULD LEARN OR THINK ABOUT BEFORE THEY HELP CARE FOR ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLE IN HOSPITAL?

For years I have introduced the Aboriginal kinship system to people working in health and legal sectors and so many other people with the purpose of increasing a better understanding of Aboriginal people and therefore creating more effective doctors, lawyers or generally anyone who is able to contribute to the progression of still the most disadvantaged people in Australia, this Nations First Peoples.

CAN YOU TELL US ABOUT SOME TRADITIONAL ABORIGINAL MEDICINES OR HEALING PRACTICES THAT HAVE BEEN OR ARE CURRENTLY USED IN YOUR COUNTRY?

There are many traditional bush medicines across the country that originate from Australia that are used in different ways to heal people, for example the Kakadu plum has been scientifically proven to contain up to fifty times the amount of vitamin C in one plum that what is found in one orange. The tamarind tree was left across the north coast of Australia by Maccassan traders in exchange for sea slug and is also known for high vitamin C benefits. At the recent Garma festival, I saw plant juice used as eye drops by Yolngu Cultural Educators.

Healing is diverse as there are many healers across many different regions who utilise localised healing practices such as the Yidaki (Didgerri Doo) healers who use sound to heal. This is very different to the desert healers who I have seen heal without touch. But I do not pretend to understand what I have seen but accept that it was a privilege to see and accept it.

ANY FINAL WORDS OF WISDOM?

I would encourage readers to research these topics I have introduced you to because it is through education that we broaden our education and therefore our worldviews. You may become quite amazed by what you discover and this may begin a new learning journey for you.

Education is knowledge and knowledge is power, so expanding your knowledge base opens you eyes to the previously unseen. As it is my job to develop medical students into health professionals, I hope to develop our students who see beyond the patient as I know I have.

Through expanding your width of knowledge, in return we develop stronger and safer communities, as we should always feel free to practice our beliefs wherever we come from, it's called being culturally safe. The rest is up to you.

DR. UNCLE RICHARD 'BALANG/JAPALJARRI' FEJO
LARRAKIA ELDER
ELDER ON CAMPUS, DARWIN POCHE SA+NT

Billy and Jordyn, FMSS VP (Left); **Billy and Loyola**, Publication Directors (Right)

EDITOR'S NOTE

I first came across the word *Placebo* somewhere between the release of Kylie Minogue's album *Fever* and the popularisation of Avocado as a breakfast food. I initially confused the word with *Placenta* and used these words interchangeably for the next couple of years. This raised some eyebrows in Year-9 science class in high school. Now it's 2023 and I get the difference.

The *Placebo Effect* is something that seems to meddle with science, yet it is so well-observed that it is part of the furniture in the scientific world. It smashes together two different ideas that humans love - Belief and Proof - ideas that are often pitted against each other. *Placebo* is a scientist's nightmare. In fact, we jump through costly experimental hoops just to negate this pesky, rather inconvenient quirk of nature. What better word to encapsulate an anthology of writing by people in healthcare, than one which blends two different ways of thinking? How better to describe the breaking of clinical protocol for the embrace of creativity, if just for a moment?

The most poignant feature you will notice in this publication is the Indigenous design. The original artwork was created by Mya Damon, an Indigenous artist. The incorporation of the design into the magazine was done by Loyola Wills, the Co-Director of Publications. It would be remiss to write about rural medicine without attempting to talk about some of the issues in Indigenous health. This idea developed with great speed, until one day, Loyola had put Mya's design on every page of the magazine.

It was from this point that I was no longer in charge of this publication and it was taking its own shape. Thank you to the contributors who have addressed this complex area of medicine. Thank you to Loyola herself, the Doctors she interviewed, and Dr. Uncle Richard Fejo, a Larrakia Elder.

Thank you to everyone who contributed their pieces of writing and their time. Despite the rural theme, we accepted submissions on just about any topic. I thought that we would just toss them together at the wall like a bit of al-dente pasta. The aim of this petit anthology is to dredge up the opinions, emotions, and beliefs that bubble under the surface of the writers' clinical dispositions. Thoughts that are sometimes washed away in the hospital by a Tsunami of hand sanitizer.

Only when they are written down, can these thoughts be really swished around, taken seriously, or in some cases, very un-seriously. In fact, take them however you want. It's just *Placebo*, after all, it isn't real... Or is it?

BILLY CHAPMAN
CO-PUBLICATIONS DIRECTOR
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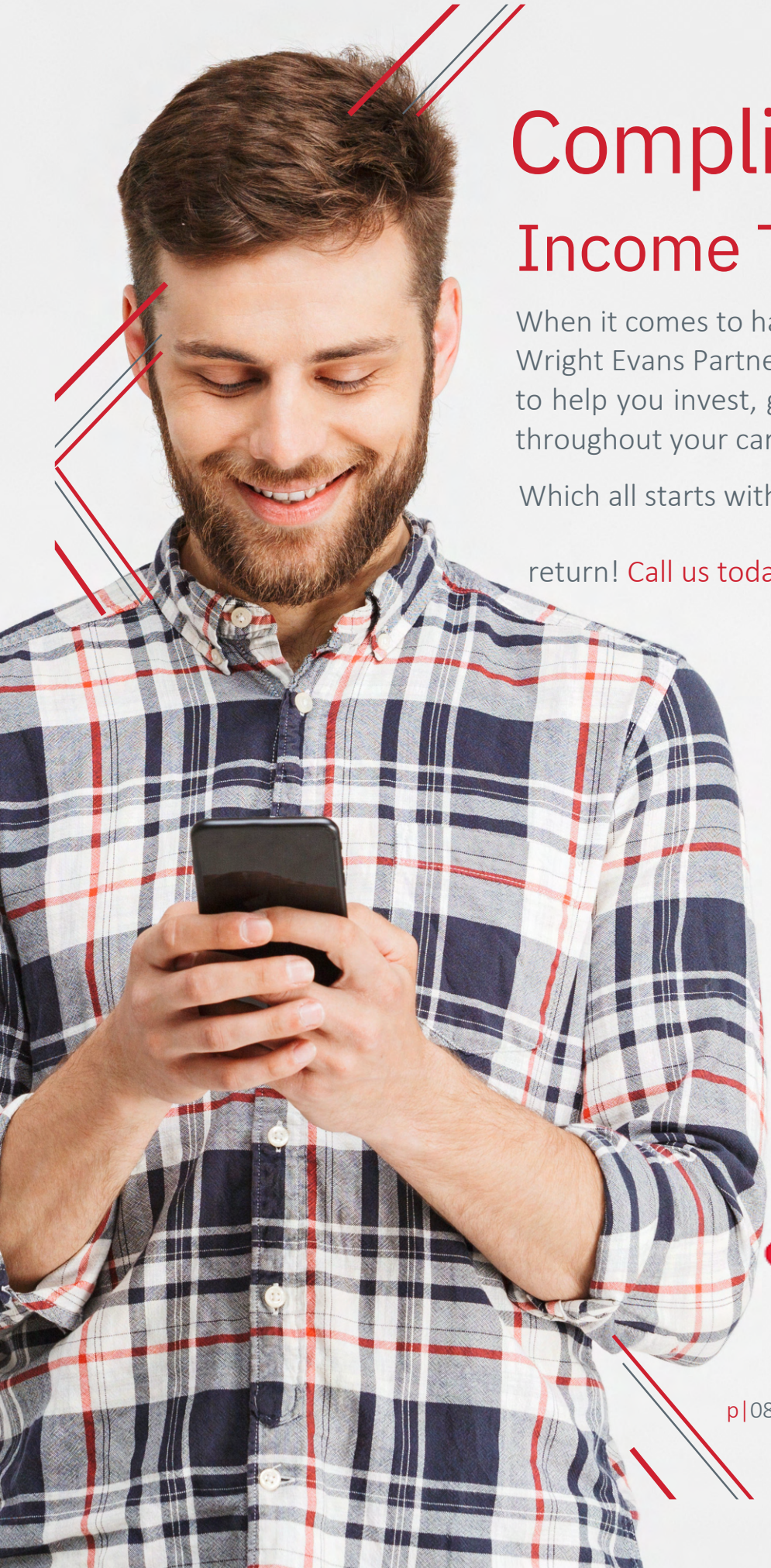

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ABORIGINAL & TORRES STRAIT ISLANDER PERSPECTIVES ON RURAL & REMOTE MEDICINE

WHO IS YOUR MOB?

I'm a Torres Strait Islander Woman with ancestral connections to *Mabuiag* and *Badu* Islands. I am a descendant of the Wagadagam tribe, whose totem is the *Koedal*, the Crocodile.

TELL US A LITTLE BIT ABOUT WHERE YOU GREW UP?

I grew up in Darwin and relocated to Adelaide for year 12 and have been here ever since.

WHAT INSPIRED YOU TO DO MEDICINE?

I was always told growing up by my teachers that I would amount to nothing. Coming from a family that had many significant health and economic issues my path was destined to find a secure job, instead of dream for what was 'unattainable'; presumedly due to being Blak. I got that secure job, and it was mind-blowingly boring af. I had a passion for being on the ground, getting amongst everything and providing support for my people. I identified Medicine as an avenue to spark the part of me that was always craving for new knowledge and a way to directly contribute back to my community in the long term. 2 babies (deferrals), and an ADHD diagnosis later and the rest is history!

WHERE TO NEXT?

I have been incredibly lucky to have gotten Internship at the Hospital I've been dreaming to work at since I started Medicine: Cairns Hospital, which lay in close proximity to my ancestral lands. Rural/remote life is definitely for me and I hope to apply to ACCRM as soon as I can.

I won't tell you all the reasons why Aboriginal & Torres Strait Islander health is extremely important in this country, the stats speak for themselves and the history a reminder of the most abominable things which have broken us. What I will challenge you to do is think about how you can make changes in your roles moving forward; meaningful changes that puts the patient in a better position than before they came in. Colleague being casually or outwardly racist? Incorrect terminology being used? Stereotypes arise? Call them out. Identify your Aboriginal Liaison Unit at your Hospital and call upon them for help/advice if you need. The tides are turning in Medicine and it's time that institutional racism comes to an end. You never know, some of your Consultants might just be Blak ;)

LOYOLA WILLS
CO-PUBLICATIONS DIRECTOR

DR DENNIS BONNEY
PAEDIATRICIAN + NEONATOLOGIST

WHO IS YOUR MOB?
I'm Wongai - my dad's mob are all from the goldfields of Western Australia. My nana was brought up on the old Mount Margaret Mission, and my pop was brought up between Laverton and Leonora. My mum's white Australian from Sydney.

TELL US A LITTLE BIT ABOUT WHERE YOU GREW UP?
I was born in Kalgoorlie, but grew up in Perth.

WHAT INSPIRED YOU TO DO MEDICINE?
Growing up, I loved the TV shows in health care facilities like A Country Practice and RFDS! I know, same job! Then when I was going through high-school I saw my mum doing a Nursing Degree, and my dad do an Arts degree, then a Masters degree. I think seeing both parents doing study encouraged me to study myself when I finished school. Additionally, in year 12, I went to an Aboriginal students' careers camp and met Dr Sandra Eades, the first Noongar doctor. She blew my mind away! She's an amazing and humble lady who I've also had the privilege of spending time with her at her work while I was on a medical student placement.

WHAT IS YOUR CURRENT ROLE?
I'm a paediatrician with two kinds of jobs. On the one hand I work in ambulatory paediatrics, looking after infants, children and young people in the hospital clinic and in a remote outreach clinic. But the type of work that I enjoy the most is as a neonatal paediatrician - going to deliveries when babies need help, and looking after them in the neonatal ICU until they can go home.

WHAT RURAL/REMOTES PLACES HAVE YOU WORKED BEFORE?
I have worked in Cairns and a few small towns/communities around there such as Babinda, Yarrabah, Mossman, Weipa, Cooktown, Wujal-Wujal, Normanton, and Mount Isa. I've also worked in Alice Springs, Newcastle and Maitland (in the Hunter Valley), Christchurch (not so rural, in NZ), and Adelaide (also not so rural, but feels like a big friendly country town doesn't it?). In the last several years I've been doing regular paediatric outreach clinics in Yurrwi (Milingimbi), which is an island community off the Arnhem Land coast.

WHAT IS THE MOST INTERESTING PRESENTATION YOU HAVE SEEN?

In paediatrics there's a few interesting conditions that we get to see. One that sticks out for me was when myself and a neonatal nurse brought around a premature baby from delivery suite to the NICU and I started to do a top-to-toe and front-to-back examination for the admission paperwork.

The baby's Dad was there and I was calling out stuff like "five cute little fingers, one cute little nose, two cute little ears ..." and then I got to the nappy area and got myself a bit a bit stuck... "hmm, the bum, I'm gonna have a bit of a better look here ...". The baby had a type of an anorectal malformation and didn't have a patent anus! So I had to make light of it with the Dad, and said that baby was otherwise made up in the usual way, but the surgeons could make his bum hole in a couple of days' time!

WHAT IS THE MOST REWARDING THING ABOUT WORKING RURAL/REMOTE?

The teams are good. People have to work well with each other 'cos we have to work with each other every day. We're also likely to live in the same suburb, or our kids go to the same school, and we take our cars (or fishing boats) to the same workshops. The neighbourly feel in the regional or rural health teams and services is more friendly.

Also, because there are smaller teams, we have to cover more specialities or types of work that people in an urban setting don't get to do, as the sub-specialists or other specialized teams are present. This makes rural/regional specialists like paediatricians stay very general, more adaptable, and need to keep up to date with the rare, or unexpected ends of the spectrum of health conditions.

WHAT IS THE MOST CHALLENGING THING ABOUT WORKING RURAL/REMOTE?

The small teams. If one of our team are sick or need time off work, there's often no pool of locum or agency staff to call upon at short notice. So if I'm on an office day, or my day off, I might need to come to work and do the acute care clinical work. Therefore maintaining and strongly protecting a positive work-life balance is important wherever we work.

WHAT ARE YOUR THOUGHTS REGARDING WHY ABORIGINAL AND/OR TORRES STRAIT ISLANDER DOCTOR/NURSES/ALLIED HEALTH ETC ARE BEST PLACED TO SUPPORT MOB IN THEIR HEALTH JOURNEYS?

We just get each other. Barriers to communication and establishing trust are almost zero by our mob treating our mob. Indigenous health in Indigenous hands is the ideal way many of us want to see Indigenous health care happen. However, supporting our mob in their health journey can happen in multiple ways. Indigenous health care workers who work in mainstream services are effecting change within the mainstream service just by being who we are.

I love taking my team for coffee after a ward round. I invite open conversation not only about clinical issues and decision making, but also broader issues affecting Indigenous patients, families, communities and all the way out to national issues. When we are equal colleagues, or even supervisors and bosses of non-Indigenous health care workers, the power in the relationship between black and white is re-examined and broader barriers are broken down.

WHAT WOULD YOU SAY TO STUDENTS WHO ARE CONSIDERING RURAL/REMOTE CAREER PATHWAYS?

Do it! You'll love it!

DR DENNIS BONNEY
PAEDIATRICIAN &
NEONATOLOGIST

DR KIARNA BROWN
OBSTETRICIAN & GYNAECOLOGIST

WHO IS YOUR MOB?
I'm Wuthathi/Yadhiagana from my Grandfather's side and Gurindji from my Grandmother's side.

TELL US A LITTLE BIT ABOUT WHERE YOU GREW UP?
I grew up in beautiful Garramilla (Darwin) on Larrakia country and I'm lucky enough to be back here raising my own family. I moved back to Garramilla after living in many different places all around the country. I couldn't imagine living anywhere else now and I'm very happy for my children to share the same type of happy childhood that I did, one full of lots of sunshine and big family gatherings.

WHAT INSPIRED YOU TO DO MEDICINE?
I don't think there was a single thing or event that inspired me to do medicine, it was more of a journey. I was an ambitious kid who loved learning and always wanted to do well. I used to say that I wanted to be a Doctor or a Lawyer or an Accountant. (Ha!) I did ok in school, not well enough to get straight into medicine, but well enough to go to University. That was pretty cool for a kid like me.

After finishing high school in Ballarat (where I lived with my grandparents), I started a Health Science degree in Melbourne. I enjoyed University, but it became apparent fairly quickly that I wasn't going to complete that degree. I didn't feel fulfilled. I took some time off and worked in the Aboriginal Community Controlled health sector for a short while. I really enjoyed it and from then I knew I wanted to work in health. It was during that time that I discovered an opportunity to study medicine. So I packed my bags and moved to Perth to enrol in Medicine at the University of Western Australia, and I've never looked back! I felt so happy, excited and privileged to study at UWA and I enjoyed every bit of my medical education.

WHAT IS YOUR CURRENT ROLE?
I have many! I spread my working week across 3 sites. I work 2 days a week at the Royal Darwin Hospital (RDH) in both Obstetrics and Gynaecology. My public appointment is the heart and soul of my employment. I have the wonderful honor of caring for pregnant women from remote Top End communities.

I also get to visit remote communities for gynaecology clinics. And I get to 'keep it real' with regular on call delivery suite shifts. I also work a day a week in the local private hospital practising gynaecology. We only have one private hospital in the Northern Territory and there are only a few of us O&G's working privately. I think it's marvelous that women of the Top End have the option for private care and I'm proud to contribute to that service. Finally, I spend the spare couple of days of the week at our local research institute, the well-respected Menzies School of Health Research. This is the big ideas aspect to my working week.

WHAT RURAL/REMOTE PLACES HAVE YOU WORKED BEFORE?

I was exposed to the benefits of rural and remote practice very early in my medical career. I loved being a member of the rural health club at UWA and our curriculum put emphasis on working regionally. As a student I spent time in magnificent places like Karratha and Broome. During my early RMO years, I had a taste of rural work in incredible locations like the Atherton tablelands in Far North Queensland. During O&G training I worked on the beautiful Sunshine Coast. And now I have the absolute pleasure of being home and travelling to some of the countries most remote communities, that are tremendously rich in culture.

WHAT IS THE MOST INTERESTING PRESENTATION YOU HAVE SEEN?

I have such a terrible memory for these sorts of things, probably because I find a vast array of things interesting. The reason I love O&G is because the presentations can be so varied and I'm constantly kept on my toes. Lots of aspects of O&G sometimes feel more art than science! For example, no birth is the same and the miracle of pregnancy and confinement NEVER gets old.

WHAT IS THE MOST REWARDING THING ABOUT WORKING RURAL/REMOTE?

Sometimes you just have to think laterally. There is definitely more than one way to skin a cat and that's something that is constantly at the forefront of my mind when I'm caring for women of the Top End, and especially for those women who live remote. Sometimes you need to be creative and navigate a system that doesn't always seem flexibile. But you must carefully consider what is the most important thing for the patient.

WHAT ARE YOUR THOUGHTS REGARDING WHY ABORIGINAL AND/OR TORRES STRAIT ISLANDER DOCTOR/NURSES/ALLIED HEALTH ETC ARE BEST PLACED TO SUPPORT MOB IN THEIR HEALTH JOURNEYS?

There has been such a long and horrible history in our country of First Nations people having terrible experiences in the health care system. I believe that what First Nations people ultimately want is to be cared for by people who they can relate to and who they feel they can trust. I feel that First Nations health care providers can often bridge those relationships more organically.

There is just an underlying mutual understanding that exists because of who we are. But, I also respect that I need allies. I can't be the only O&G who looks after all of the First Nations women in my hospital, because that's not right either. In fact, it's impossible! So we need our health workforce right across the country to gain an understanding and to want to learn how to do better.

WHAT WOULD YOU SAY TO STUDENTS WHO ARE CONSIDERING RURAL/REMOTE CARRER PATHWAYS?

Do it! But make sure you immerse yourself in your community. Find somewhere that your heart feels happy, and where joy comes easily. Listen and learn, but teach and provide. You will be amazed at the wonderful opportunities that come your way when you throw positive energy out into the universe.

DR KIARNA BROWN
OBSTETRICIAN &
GYNAECOLOGIST

DR NATHAN PASSI
EMERGENCY MEDICINE ADV. TRAINEE

WHO IS YOUR MOB?
My family originate from Mer (Murray) Island in the Torres Strait. Two of my ancestors were plaintiffs in the Mabo Case – my great grandfather Sam Passi and his brother David Passi.

TELL US A LITTLE BIT WHERE YOU GREW UP?
I was born in Mt Isa, which is in North Western QLD. My family lived in Cloncurry. We moved to Townsville for better schooling and educational opportunities in early primary school.
I finished primary school and high school in Townsville, and completed my primary medical degree at JCU, graduating in 2014.

WHAT INSPIRED YOU TO DO MEDICINE?
Hospitals have always felt very welcoming and homely to me. If I could pin it down, it was probably my exposure to health services when I was young. My Nanna worked at Community Health in Cloncurry, and so I was always at the Community Health Clinic growing up. My great grandfather was also diagnosed with lung cancer when I was in my early childhood. So I spent a fair few months in Brisbane with him, while he was receiving cancer treatment.
I think I was 5 or so at the time. So in a way I have grown up in a health setting.

WHAT IS YOUR CURRENT ROLE?
I am an advanced trainee in Emergency Medicine, and work as a registrar at the Townsville University Hospital Emergency Department. Initially I was a rural generalist (ACRRM) trainee, but transitioned to ED training with ACEM while working in Mt Isa ED in 2017. I am co-chair of my local transforming ED towards cultural safety committee, and sit on the local Aboriginal Torres Strait Islander Health Leadership Committee and am a member of the Indigenous Health Committee for the Australasian College of Emergency Medicine. I am also a mentor for our local indigenous intern pathway in Townsville.

WHAT RURAL/REMOTE PLACES HAVE YOU WORKED BEFORE?
Mt Isa, Proserpine, Palm Island. As a medical student I completed placements in Mossman, Mt Isa, Cloncurry, South Africa and Singapore.

WHAT IS THE MOST INTERESTING PRESENTATION YOU HAVE SEEN?

This is a difficult question, but there are a few presentations that have stuck with me over time.

1. An Indigenous lady who I saw in Mt Isa, who was flown via retrieval services from Lake Nash in the NT. I was asked to see her as nursing staff were concerned she was confused because she wasn't really communicating with them, she wouldn't get on the hospital bed, and she had soiled herself. On talking to her, she was confused.

English was not her first language, she had never been in an environment like the Mt Isa ED before, and had not seen a bed like a hospital bed before. She soiled herself, because she was scared to ask where the toilet was. Her diagnosis ended up being simple, but her presentation highlighted some of the complexities of Indigenous health care. If these complexities were not identified, it is not hard to imagine that this patient's clinical course could have been very different.

2. When I was on an elective (OBGYN) placement in Cape Town South Africa, I saw a lady in clinic who was from a northern African country. When she found out she was pregnant, she walked from her country at the top of the African continent, all the way down to South Africa. By the time she got there, she was term. She was living in a shanty township on the outskirts of Cape Town. Again, she had never lay in a bed before! She was very confused when I asked her to get onto the bed so I could examine her. In order to seek better healthcare, this lady walked for most of her pregnancy. I will never forget that.

WHAT IS THE MOST REWARDING THING ABOUT WORKING RURAL/REMOTE?

For me, one of the most rewarding things about working rurally/remotely I think is that you are providing a service to people who would otherwise not have access to the same level of healthcare otherwise. You get to provide medicine to people in their communities, which allows them (most of the time) to stay in their communities and not have to go to a bigger centre. That is so important. You have a chance to make real and holistic changes in people's lives.-

The second rewarding thing is work life balance. You don't have to compete with morning traffic, everyone at work will know your name, as will most members of the community you work in. You will develop close relationships with your patients, and your colleagues, and rural communities are often very welcoming.

WHAT IS THE MOST CHALLENGING THING ABOUT WORKING RURAL/REMOTE?

Funnily enough, I also found the most challenging thing to be work life balance!! For example, on Palm Island there were times when I was the only doctor on the island from Friday to Monday. Rounding during the day, being on call during the day and night took its toll. It was not that uncommon to spend 20 or so hours at work in a 24 hour period if you were on call. It can also be hard to see people you develop connections with become sick, as you don't have the same degree of separation from your patients you would in a bigger place.

WHAT ARE YOUR THOUGHTS REGARDING WHY ABORIGINAL AND/OR TORRES STRAIT ISLANDER DOCTORS/NURSES/ALLIED HEALTH ETC ARE BEST PLACED TO SUPPORT MOB IN THEIR HEALTH JOURNEYS?

I don't think that we are always best placed to support mob, as there are plenty of non-Indigenous health professionals who have extensive experience in Indigenous Health and have made significant contributions in this area! However, I think it's important that Indigenous people see people like them who are health professionals - that alone is very empowering. Having someone who looks like you, has a similar story to you, has similar connections to you, someone to emulate and aspire to be - that creates opportunities. That's when kids go, hey - I want to be like them! Indigenous people should feel that they CAN take control of their health and create real change. One day I hope it will be very normal to have an Indigenous Doctor/Nurse or allied health professional treating patients!

WHAT WOULD YOU SAY TO STUDENTS WHO ARE CONSIDERING RURAL/REMOTE CAREER PATHWAYS?

I have no regrets about the time or training that I have spent in Rural/Remote areas. In many ways I gained clinical advantages by being exposed to Rural Medicine. I had more hands on teaching, I attained registrar positions/responsibilites earlier, I learned Advanced skills early and I was exposed to a wide range of pathologies early - which forced me to develop my clinical skills (often without relying on pathology and imaging beyond a basic X-ray).

I made life long friends and made many memories that will last a lifetime. I would say that even if you don't intend on working rurally in the long term, do some rotations or chase some rural experiences - you won't regret it. At the very least, you will have an understanding of the challenges faced by your rural colleagues and rural health disadvantages faced by your patients!

DR NATHAN PASSI
EMERGENCY MEDICINE ADV. TRAINEE

DR JEANETTE WIMBUS
GENERAL PRACTITIONER

WHO IS YOUR MOB?
Torres Strait Islander (Badu) and Australian South Sea Islander. I am still discovering many connections to different groups today!

TELL US A LITTLE BIT ABOUT WHERE YOU GREW UP?
I grew up in Bundaberg, sent myself to boarding school in Yeppoon when I was 14 yo.

WHAT INSPIRED YOU TO DO MEDICINE?
When I was 5 yo I told my mum I was going to be a doctor to help the children in Africa. After many young deaths within my family, especially my Pa (he was 58 yo and I was 9yo), I realised the health of my family and people was on par with Africa.

WHAT IS YOUR CURRENT ROLE?
I am currently a GP.

WHAT RURAL/REMOTE PLACES HAVE YOU WORKED BEFORE?
I have worked in Ingham and done placements in Weipa, Woorabinda and Ayr.

WHAT IS THE MOST INTERESTING PRESENTATION YOU HAVE SEEN?
Oh gosh. I remember an Aboriginal woman in her 50's came in to DEM with a sore ankle after tripping the night prior and 'thought I'd get it checked as it's still a bit sore'. She had a completely displaced fracture of her distal fibula and tibia. And she just walked in with a bit of a limp like it was nothing.

WHAT IS THE MOST REWARDING THING ABOUT WORKING RURAL/REMOTE?
Where I work now is regional. But I hope to eventually work possibly FIFO remote. I loved it. You get to know your patients on a more personal level and you are a part of a big family, the community.

WHAT IS THE MOST CHALLENGING THING ABOUT WORKING RURAL/REMOTE?
The same as the most rewarding. By being a small community, there is little privacy or personal life. It is difficult to socialize as the community are your patients. You want to let your hair down and be yourself but you also don't want to undermine your patients view of you as a professional.

WHAT ARE YOUR THOUGHTS REGARDING WHY ABORIGINAL AND/OR TORRES STRAIT ISLANDER DOCTOR/NURSES/ALLIED HEALTH ETC ARE BEST PLACED TO SUPPORT MOB IN THEIR HEALTH JOURNEYS?

We understand our mob on a level that non-Indigenous professionals never will. We have an understanding of family dynamics, social aspects, culture, lore etc. We have a level of trust and connection to our own people. This is paramount in bettering the health of Aboriginal and Torres Strait Islander people.

WHAT WOULD YOU SAY TO STUDENTS WHO ARE CONSIDERING RURAL/REMOTE CAREER PATHWAYS?

Get in there! Try it! It is so rewarding caring for entire families, communities. Being accepted and involved and embraced by a whole community. You will see and experience things you never would in big cities. You have the opportunity to experience and embrace the oldest living culture in the world and some of the kindest, giving and most amazing people.

DR JEANETTE WIMBUS
GENERAL PRACTITIONER

DR NATALIE PINK
RURAL GENERALIST
(ABORIGINAL & TORRES STRAIT ISLANDER HEALTH & ACADEMIC PRACTICE)

WHO IS YOUR MOB?
Nykina.

TELL US A LITTLE BIT ABOUT WHERE YOU GREW UP?
I grew up on Kaurna country, in the southern suburbs of Adelaide. Single income family, eldest of 3 daughters. Many trips were made back up through Central Australia back to the Kimberley to visit family there - I still have a strong connection to the Kimberley.

WHAT INSPIRED YOU TO DO MEDICINE?
My grandparents were often needing hospitalisation and management of chronic conditions by their GP, so I had quite a bit of exposure over my young years to the medical world as a consumer/family member. I also had renal disease at the age of 2 years old which landed me prolonged admissions in hospital. I always remembered the Doctors that treated me and my family members. My mother has some bad experiences with the medical field, and I wanted to be part of the change to make it better. I first became a paramedic out of high school and met some amazing people along the way - trauma specialists as well as work partners who went on to chase their dream of doing Medicine, I soon followed suit. I was lucky enough to complete postgrad Medicine with my youngest sister.

WHAT IS YOUR CURRENT ROLE?
I finished a fellowship from the Australian College of Rural and Remote Medicine as a Rural Generalist with Advanced Specialist Training in Aboriginal and/or Torres Strait Islander health and academic practice. Since fellowship, I have been locuming in rural and remote regions throughout Australia.

WHAT RURAL/REMOTE PLACES HAVE YOU WORKED BEFORE?
Port Lincoln, Angaston, Yalata, Murray Bridge & soon to be Weipa.

WHAT IS THE MOST INTERESTING PRESENTATION YOU HAVE SEEN?
Recently I had an inpatient who had a severe reaction to Vancomycin, similar to DIC and I later learned it was most likely Vancomycin-induced immune thrombocytopenia.

WHAT IS THE MOST REWARDING THING ABOUT WORKING RURAL/REMOTE?

The people you care for really appreciate your service and you can make a real difference to their health and patient journey. They often are not afraid to give you their gratitude and they are also more than happy to share their wisdom about the area or exchange plants or recipes and other life stories than can further your knowledge outside of Medicine.

WHAT IS THE MOST CHALLENGING THING ABOUT WORKING RURAL/REMOTE?

I would have to say the isolation - not so much from help as there is always someone you can call for advice but sometimes the distance from physical help is most challenging. There is often only so much you can do in a remote place to treat conditions and you can't just order bloods or imaging, you need to rely on your history taking and clinical examination to make your provisional diagnosis. Equipment can be scarce or non-existent so you need to become good at thinking outside of the box or re-purpose what you have available to treat the person. When I call a tertiary hospital for advice to transfer, the person on the other end often is not aware of these additional challenges and sometimes not even aware of the distance from some of the more remote places i.e. getting someone to simply drive to ED in the city for transfer (for some of the places I've worked this journey is over 8hours by road!)

WHAT ARE YOUR THOUGHTS REGARDING WHY ABORIGINAL AND/OR TORRES STRAIT ISLANDER DOCTORS/NURSES/ALLIED HEALTH ETC ARE BEST PLACED TO SUPPORT MOB IN THEIR HEALTH JOURNEYS?

We bring a lived experience and understanding of the whole situation - life can be chaotic and require flexibility, sometimes there are cultural and social concerns that need to be addressed before the medical issues. We also tend to have a different way of communicating with mob, helping mob feel relaxed and listened to, valued.

WHAT WOULD YOU SAY TO STUDENTS WHO ARE CONSIDERING RURAL/REMOTE CAREER PATHWAYS?

It is not an easy journey, there will be many steep learning curves along the way but you won't regret any of it. If you love a challenge, problem solving, speaking to people, seeing real pathology, practicing many facets of Medicine and learning about life - then a career in Rural and Remote Medicine is for you!

DR NATALIE PINK
RURAL GENERALIST

'ARTS IN HEALTH'

INTERVIEW WITH JAKE GOSS, MUSIC THERAPIST
BY BILLY CHAPMAN

TRANSCRIPT

Billy
What does the Arts in Health Unit do in the hospital?

Jake
We work alongside the other allied health teams. We're an allied health team. We have art therapy and music therapy, which is allied health, and then a bunch of other staff that support us.

Sometimes we're working towards actual patient goals, as in the technical plan, so that might be more with mental health patients. But other times we're supporting the patient and supporting the other clinicians to help achieve the best patient outcomes possible, so whether that be with someone with Dementia, getting them oriented to the space, or to reduce Code Blacks, or helping someone with an eating disorder to feel more comfortable and relaxed.

to eat their food or settle after eating new foods so they don't want to purge. Things like that. And also, we've got a whole bunch of galleries throughout the hospital, and this helps just change the atmosphere from a totally clinical perspective and makes it a bit more human.

Billy
Are patients creating a lot of those artworks around the place?

Jake
Yeah, it's good question. So, for visual arts, we do have a patient gallery. This is when some particularly creative people, well actually they don't have to be amazingly creative, but if they are more physically well and therefore able to produce something and they want to display it, they are welcome to put their mark up on the wall there. So, mostly in the art orientation sessions, they will be creating themselves. But in their music sessions often I'm working with people that don't have the capacity to actively create, sometimes I will do some writing with people, or play the Ukulele with people, but often they're in a critical state and I would just simply play music or run a meditation and use that as an entry-level for what could be counselling. It just reduces the barrier. If I can give a bit of myself and play a song, that can often open up into a very genuine conversation, and then they are more willing to talk about their experiences in the hospital. So, all our therapists and all music therapists are trained in counselling.

Billy
Does the music serve as an icebreaker for a counselling session?

Jake
It's quite a common pathway by which people will start to talk about their experience in the hospital. So, it certainly can be. And then the interesting thing is, the patient will then have control of how much they want to disclose. They can always say, 'Hey, can I just listen to some music now?' Or they can lean back a bit into something which doesn't have to be so direct, which is a little bit different to something like a Psychology session where it's a bit more overtly obvious that you're there to talk about your feelings, which can be a bit more confronting maybe. It's a bit more of a softer approach with music therapy. That's our perspective. Some people don't need counselling, don't want counselling, they want to connect from just a human level. And yeah, if that's what the patient needs then that's what we offer.

Billy
How does it work in terms of referrals? Or how do you get involved in the care of a patient?

Jake
We work the same as the other Allied Health teams, we're a referral-based team. And so most often a social worker, a doctor or a nurse would just notify us if someone's isolated, like they don't have any family around, often we work with people from the Gambier or Darwin, if they don't have any visitors. Also, if they are in a lot of pain and the pain medication isn't working so much, so we can help support them from a different angle. Or say someone's wandering, we often get referrals for those patients who are disorientated. And then also the psych team has a blanket referral for us for all the new eating disorder patients just because it's proven to be quite an effective complement to their care. So yeah, there's a whole bunch of reasons that someone might be under particular distress, or sometimes just people who are extra creative and want to exercise that creativity during their stay.

Billy
Are there any particular challenges about what you do?

Jake
Yeah, so we only work a certain number of hours in the day, and we would love to see everyone but because it's a 600 or 700 bed hospital we just feel a bit stretched thin. That's one issue. Particularly with patients with eating disorders, I would like to see them every morning to support them with their eating but I'm only here 12 hours a week and the other guys are here 6 hours a week and it just makes it a bit tricky. There are plenty of ideas and enthusiasm but not always the resources in place. As creatives, we have lots of big ideas, but we just don't have the funding all the time. It's a pretty amazing job, to be honest. I sometimes get people saying, 'Oh, this must be the best job in the world,' and yeah it's

true, the stuff we do is really, really great and fulfilling.

Billy
I do remember as a student we had to do an 'Arts in Health' elective and I chose 'Music in Medicine' and ended up being sent to the wards to play songs for people, and it was a strange combination of fulfilling but also terrifying.

Jake
Oh yeah?

Billy
Yeah, I found it really difficult just because you feel a lot more vulnerable performing in front of patients when you are so used to a certain style of communication which is more controlled and professional. I felt a lot more nervous than I normally would interacting with patients, more vulnerable or something like that.

Jake
It's so interesting that you bring that up because that is something I draw upon in sessions quite often actually. For example, sometimes when a person with an eating disorder is eating in front of me for the first time, I will play a song that I feel uncomfortable with and we can sort of share the load of feeling uncomfortable. So, I am learning a song and singing notes wrong and then they are eating lunch and struggling with that. Sharing the burden can be great, and just trying to think of ways to match the emotion of the person in front of you. Often, I work with people who want to sing but might be a bit uncomfortable about singing, and I'm not a trained singer actually, I'm a saxophone player, but here I always play the guitar and sing and I feel that people tend to be more invited to want to sing along when they haven't got someone intimidating singing to them. In fact, when we were learning, we actually had lectures on how to sort of dumb down your voice a little bit... which I did not have to pay too much attention to... but yeah that is a genuine strategy that is taught.

Billy
Sometimes I have this thought that... Someone who's in a leadership position, whether it's a high-level nurse, high-level doctor or whatever. I wonder if it would almost help their interactions with patients if they had to do something like a performance or something that would bring them down a peg and make them look silly. Because those workers in hospitals are often very slick and in positions of power, and I get there's a reason for that, and maybe people need reassurance, but also it would be interesting to see what would happen if you disrupted that hierarchy.

Jake
Yeah, absolutely. And maybe that dynamic is what people need sometimes in a health-care worker, to have that feeling of authority questioned, but definitely, from a mental health perspective, it's really great when you can break down hierarchy and be even. In some cases, I've seen medical staff and nursing staff being prepared to join in with music sessions. Then, the patients all of a sudden are able to teach these doctors and nurses how to change the chords of a song or something so the doctors are in a place of vulnerability. I think that dynamic can be really beneficial for the relationship. Yeah, it's interesting. I love thinking about all that sort of stuff.

Services offered by Arts in Health at FMC:
Music therapy, Art Therapy and Facilitation, Harp Player, and Creative Writing.

IMAGE BY HUGO, AT HOME

'GOING RURAL'

INTERVIEW WITH HUGO KELLER
BY BILLY CHAPMAN

TRANSCRIPT

Billy
First things first, where are you from? Where were you raised? and maybe tell us what it was like.

Hugo
I'm from Tintinara over on the Southeast, on the Dukes Hwy, which is about two hours out of Adelaide, so if you've ever driven to Melbourne, you would have gone through it or down to Mount Gambier.

Small town, and then I think the census one year ago said it was about 500 people. The school had 125 in its heyday. Five in my year 12 class. I'm one of six. So five young sisters and me. So big sort of family they probably played a large part in who I became. I was like a pseudo-father for [the youngest three]. I spent a lot of time just working on the farm and that was what I was going to do for a long time. And then my dad told me when I was about 13/14 that I needed to do something else first, just in case the farm went belly up or anything. So, I thought I'll go get a trade.

Billy
Then what happened?

Hugo
... When I was 12, my younger sister was born premature and I saw a lot more of the doctors then. I really liked how the paediatrician was engaging with my mum... We would have to drive all the way to Adelaide to be seen and mum was always very nervous in the waiting room... Seeing how reassured Mum was afterwards by the Paediatrician and his manner, and how engaged and comforted they made her feel.

Billy
What do you think makes a good doctor? What do you think makes a good rural doctor? Are they the same? Are they different?

Hugo
Different, I think. The times that I've been exposed to rural doctors and some of the places I've seen, they've likened it to old-school medicine. And that they haven't got as much technology available. Sure, you can do blood tests now and as it's changing more and a lot more services have imaging available, but it's the sort of things that you can't do straight away. Ordering blood tests quickly and getting scans back. I think for a rural doctor, you really need to rely on clinical skills... I think honesty is also really important in the country, given that you might have less information, you just need to tell someone if you don't know exactly what is going on.

Billy
Let's look forward, what do you see in terms of the future of rural general practice? Is it sort of the same, is it changing? Does it need to change?

Hugo
I think it's slowly being dragged towards change like you're seeing a shift in dynamic from 20 to 30 years ago where you had one to two GPs in a rural town and they ran it and that was it and you had lots of small GP clinics like that around. So we're seeing a trend towards larger rural towns having 6 to 8 GPs and then people coming from the surrounding communities to that site. That gives better work-life balance for the doctors there. And there's that burnout aspect, which I think from discussions that I've had through my research, it seems the senior GPs are saying that a lot of the new ones coming through are smarter. They want that work-life balance, they want better care for their patients and they don't want to miss things by being burnt out so I think the rural GP premise really is having to change to a more hub and spoke model where you're having larger centres.

Billy
As you know, there is some doom and gloom presented about general practice, both metro and rural, I've heard stories about not having enough GPs, about towns losing their populations, fewer jobs being available etc. How does that kind of exposure, or how does that story make you feel as someone who is interested in that career?

Hugo
It certainly puts you up against the edge of it – where you want to be a rural GP – but you want to do it in a way that it's going to be sustainable for you. I think for me when I heard those stories, it reminds me that I can't be in a town that only has one or two GPs. I need to go somewhere that's established, that's got support networks in place. That has several GPs there already. I am happy that these issues are in the media though. Because if it's in the media, it brings it up into the public eye, which then puts more pressure on the powers to be to try and change things and implement more funding. Like we're seeing now that if you work rurally, they'll wipe some of your HECS debt and that sort of thing. So those incentives to get people to go rural are a result of that media coverage.It can also scare people away from wanting to go out though. Or add to the misconceptions about living rurally, so it's a double-edged sword in that it may be pushing some people away.

Billy
What are some of those misconceptions?

Hugo
I think some of them would be – that there's no support. I mean that is wrong because there is always support in some form. It might be different to what you think of in the city, but when you're in metro and you need to consult with Cardiology or something, you are going to call them, not walk down to their office. The funny thing is that you would do exactly the same thing in the country.

Billy
You mean something like iCCnet – specialist rural cardiology services, and things like that.

Hugo
Absolutely. So, how often are you going to have a 24/7 phone service that puts you straight through to a consultant cardiologist when you're in metro? That doesn't happen in city hospitals, you have to call for consult and go through a Registrar.

Billy
Anything else?

Hugo
Then there's the isolation aspect, or that it is boring as a rural GP because you just see that same thing all the time. That is just not true because you get all sorts of people coming in. With all sorts of things. You know, crashes on the river, trauma, and stuff like that. You are sort of the emergency doctor as well.

Billy
Are there any challenges that come to mind that are specific to being a rural practitioner that you would worry about?

Hugo
I think for rural practice it's workload. That's a big one because there are always patients wanting to be seen. Although you're part of the community, there's this other aspect of remaining professional and keeping yourself somewhat removed. Because you're not just a number, you're a face, so you may see your patients out in the community and you may have their test results or you may know something that shouldn't be shared. You can't just bring that up with them there, and if they try and bring it up with you, you sort of have to guide that conversation away and keep it to the practice. So, maintaining the balance between work life and social life would definitely be the hardest thing about the workload in rural practice I think – and juggling between friendship and professionalism

Billy
What are your thoughts on the statement that we all get asked which is – are you going to specialise or are you going to be "*just a GP*?"

Hugo
Yeah, that's a classic. It's a big misconception. I mean, you even see it in comedy skits and that sort of thing people like, you got a headache? I'll send you to the Neurologist. Ohh. A heart problem? I'll send you to the cardiologist. I mean obviously, they do a lot more than just sign-posting and directing. They're the ones who can try and keep pressure off our health service, and we're feeling it now in hospitals, what happens when primary care is not functioning properly. I was talking to one of the doctors who has family in Germany, and they don't have any General Practitioners. They all just have specialists there, I think we are very lucky to have GPs here in Australia to help with the monitoring process where you can review again and look for further changes. If you go to an ED you'll be sitting there for God knows how many hours, and then will get lost to follow-up anyway. So GPs are a really important part of taking the pressure off.

Billy
What challenges exist for practitioners in the area of Indigenous health? Perhaps for people like yourself, who do not have that shared cultural experience. How do you intend to deal with these challenges when you are practicing next year?

Hugo
I think there's the trust component. Trying to build as much trust as possible. Speaking to some of the non-Indigenous GPs, they talk about how people living in rural and remote areas, not actually just Indigenous people to be honest, but anyone living there, they often set their own time and they do things in their own way.

This can sometimes be cultural, but also sometimes purely logistical, like some people are travelling a lot. I have been told that you shouldn't push or pull too much, you can't be overbearing, and you can't be trying to force your Western-based medicines and policies onto someone who does not subscribe to them. So, I guess just trying to be appropriate in the context of someone's culture and their situation.

Billy
That seems like it would work as a pretty good general rule as well.

Hugo
Yeah, but I mean for the Indigenous population I imagine there is generational trauma there as well, with the background of institutions and places like hospitals which are all clean and clinical. I guess structures like that can be really anxiety-provoking because of past trauma. Same thing for older people as well because hospitals are seen as end-stage. So, for people who have such a strong connection to land, a hospital could be really traumatic. I think it is important for anyone to just be aware of these things and respectful of that, and try to engage and see things on their terms. And I guess this is for all patients. You should be just a guide. You shouldn't be the master in charge. It's their body, it's their life, it's their health.

Billy
Is there anything that you would like people who are not going into rural practice to take from all of this? What's their role?

Hugo
I think you need to appreciate [rural health] regardless of your location. I think even if you're dead certain you're not going to go rural, you're given an opportunity to experience it, to see what the other side's like. As I was saying earlier, a lot of us, nearly all of us, will do our internship in the metro hospitals. But, we need to have an idea so that when we're transferring patients away we know a bit about where they are going and the resources they have, or the travel they have to undertake. Then you'll have a bit more of an understanding of what needs to be done to get them there, and how to stop things from escalating again.

HUGO KELLER

IMAGE BY HARRY GAFFNEY

RURAL MEDICINE
EMBRACING ADVENTURE IN A CLOSE-KNIT COMMUNITY

DR HARRY GAFFNEY, LCLHN RURAL MEDICINE INTERN

Living it up in the Countryside with Delightful Encounters

As a rural doctor, you become an integral part of the community, recognised not just within the hospital walls but also on the streets and in local establishments. Engaging in heartfelt conversations with the friendly postman, who knows you as the doctor who saved the day, will become a regular occurrence. The support and gratitude you receive from patients and peers will be remarkable.

Unparalleled Community Vibes

The beating heart of rural medicine lies within the local community. The level of camaraderie is so extraordinary that we are organising a captivating music jam session right in the hospital! Witnessing the overwhelming response from community members and colleagues who eagerly join in is awe-inspiring. Whether you're wielding a stethoscope or strumming a guitar, we stand together, looking out for one another. Moreover, our Young Professional Group is a haven for those new to the area, fostering social events and casual gatherings. So, bring along your partners, colleagues, and furry companions – everyone is warmly welcomed!

Unforgettable Adventures and Core-Memory Moments

On my first day as an intern, a wave of chaos crashed upon us when a patient arrived with

excruciating abdominal pain. Fear not! With the guidance of my consultant, we swooped in and swiftly alleviated their agony and restored comfort. Witnessing the patient's pain dissolve and feeling their profound gratitude was nothing short of magic. Such thrilling, challenging, and ultimately rewarding experiences await you in rural medicine.

Advice for Thrill-Seeking Med Students

Are you ready to unleash your inner adventurer? Pay heed, my esteemed medical peers. Do not hesitate for a moment to embark on this exhilarating journey. Yes, relocating may appear daunting initially, but trust me when I say it is worth pursuing. Step outside your comfort zone and uncover the wonders of rural medicine. I assure you; it will be a decision you will never regret.

Once you immerse yourself in this remarkable environment, prepare to be astonished. Working within a close-knit community will bestow upon you unparalleled satisfaction. You will forge deep connections with your peers, and the gratitude emanating from your patients will warm your heart. Your unwavering dedication and hard work will not go unnoticed by your mentors and colleagues. Witnessing patients transition from being confined to their beds to joyfully playing with their beloved pets in the park, all thanks to your intervention, is an unparalleled experience. Such is the impact you can have in a smaller community.

So, brace yourselves for a thrilling expedition through the realms of rural medicine. Pack your sense of adventure and join us on this transformative journey. Life-changing experiences, unwavering support, fun and excitement await you. Get ready to become the doctor who becomes part of a fantastic community while improving community health.

IMAGES BY KAITLYN SPOONER

COGNITIVE DISSONANCE
A PERSONAL REFLECTION ON ECOLOGY AND MEDICINE

JAIDA BUCK

I recently returned from a week-long trip to Aotearoa. After a gruelling semester, being outdoors in the company of a good friend grounded me. Whilst I enjoy medicine - the challenge of comprehending the human body - it is not my first love. My first love is ecology. I felt the fire return as I wandered around the bird sanctuary in Wellington, tramped Tongariro Crossing, and poured over beautiful museum exhibits. How could I have left behind this world of science and curiosity for the pressure-cooker of studying medicine?

When I was ten years old, I read 'We are the Weather Makers' by Tim Flannery. It profoundly changed my life. I became that climate kid and began my crusade to save the environment. My love for famous naturalists like David Attenborough and Jane Goodall blossomed.

I was wide-eyed and innocent, wanting more than anything to explore nature and live in the forest. It was around this time that I experienced my first bout of utter hopelessness with the world. Existential dread lurked at the corners of my mind. It was all-consuming. I was horrified at how capable humans were of destroying the planet.

They have invented language now that describes what I felt over a decade ago. Ecological grief is "the grief felt in relation to experienced or anticipated ecological losses, including the loss of species, ecosystems and meaningful landscapes due to acute or chronic environmental change. (Cunsolo, A. & Ellis, N. R. 2018). It is a sense of stuckness and incapability that now feels worn and familiar.

As I got older, my passion was dampened by the realities of adult life. There are everyday sadnesses, disappointments and responsibilities that we carry as burdens with hunched shoulders and gritted teeth. I almost became the adult that my child self deeply resented - resigned, compromising and stagnant. Episodes of ecological grief were replaced by intermittent spells of apathy. The thought of writing grant proposals as an ecologist and being constantly dismissed was dispiriting.

My friends at the time held more respect for the caring professions than for scientists, so I drifted from my enthusiasm for environmental issues, and coasted toward the notion of becoming a doctor. I felt that at least amongst people, I would make a difference I could measure. And maybe if I was a doctor, people would listen to what I had to say.

Of course, medicine is mostly a form of firefighting. We don't focus enough on illness prevention. Just like a lot of ecological interventions, we favour band-aid solutions over resilience building. It is for this reason that medicine is often personally rewarding, with the fruit of your labour offering instant gratification. That dopamine hit is addictive.

Regardless of how consuming this alternative pathway in medicine tends to be though, I cannot unlearn my ecological education. No matter how far I drift from that anchor, the rope tugs persistently at my heart. Sometimes I ignore it, fiddling idly with my tether, but I know I need to trace it back to its source. Without that ecological anchor, I would be adrift.

Yet, like an anchor, ecological education is heavy. Arlo Leopold understood this when he wrote his essay The Round River in 'A Sand County Almanac'.

One of the penalties of an ecological education is that one lives alone in a world of wounds. Much of the damage inflicted on land is quite invisible to laymen. An ecologist must either harden his shell and make believe that the consequences of science are none of his business, or he must be the doctor who sees the marks of death in a community that believes itself well and does not want to be told otherwise.

Arlo Leopold - 'A Sand County Almanac'

Read this twice. See how naturally he draws an analogy between ecology and medicine. Could the same not be said of those educated in medicine that they 'live alone in a world of wounds'? Much of the suffering seen by medical practitioners is subtle, invisible, chronic and highly emotional. But we separate ourselves from the magnitude of suffering that we witness otherwise we would become paralysed.

We act contrary to our distress. We are as paradoxical as superstitious atheists. What Arlo Leopold describes eloquently is the cognitive dissonance that a hurting world full of hurting people can induce. I do not intend to be melodramatic, but be it in the environmental space or preventative healthcare, without some proactivity we are inevitably painting our own gravestones. This is a terrifying realisation for those educated in any field dealing with the realities of this world. I've received a double dose.

To me, decoupling medicine and environmental justice is counterintuitive. Where is the joy in restoring someone to 'health', when the world you release them into equally needs healing, and their environment is not conducive to health maintenance? Their home could be ravaged by an extreme weather event, increasing in frequency due to climate change. Their asthma could flare up from poor air quality due to anthropogenic causes. Their kidney condition could be exacerbated by extreme heat.

Or perhaps, like me, they are at risk of becoming thoroughly depressed as they look to the future of life in the anthropocene, and see around them the constant degradation of beautiful things. The environment is straining under the weight of our actions. With all the medical care in the world, how is a person supposed to thrive?

Last year I read an article about 'Green Nephrology' (Barraclough, K. A. & Agar, J. W. M. 2020). The basis of this movement is that the incidence of kidney injury will rise as the frequency of extreme heat events increases.

This link between climate and health is motivating nephrologists to reduce water usage and waste production from dialysis and other kidney care. It is these kinds of direct links between health and environmental issues that could elevate the medical dialogue into the ecological space, and it is such conversations that give me hope.

This hope becomes fragile when I face the kind of existential loneliness that Leopold speaks of, especially in relation to species loss and habitat destruction, which cannot be easily undone. At a personal level, this sense of abandonment is exacerbated when as a medical student I am overwhelmed with content and expectations that I can only ever partially fulfil.

How can I invest in my understanding of the natural world whilst simultaneously learning the complex anatomy of the hands and the rheumatological conditions that deform them? How can I remember all the bird species in my Ultimate Birds Anki Deck when I can barely remember a flashcard about osteosarcoma. I have already seen 5 times today?

The constant barrage of information starts to smother my curiosity. I regress to a state that would disappoint my child self: I exercise, listen to music, get hungry and sleep (or try to). But I still don't know my lesser sand plover from my greater sand plover. The art of deep observation is lost and I become disgustingly short-sighted. I feel even more discouraged when my environmental passion is (unintentionally) brushed off by my peers as a side-issue.

But every moment of reprieve brings me back to the anchor. My shell refuses to harden to the point where I view the consequences of science as 'none of my business'. So I spent the summer doing ecological fieldwork with my old conservation biology professor: digging, setting pitfall traps, measuring and releasing lizards and small mammals, getting excited about moths clambering at night over a white sheet lit up by the headlights of a 4-wheel-drive. This is how ecologists measure biodiversity in the field.

As I reconnected with the world, I learnt that geckos can be identified by their feet. Some have padded toes with no claws, whilst others have claws that cling to your fingers with a human-like grip. Dunnarts and pygmy possums are both marsupials, which also grip you with dextrous 'hands'. They are endearing, although they sometimes bite. This seems understandable.

Handling these animals reminded me of how reliant they are on our actions as humans. Just as doctors are trusted with the lives of their patients, and the decisions they make can have huge implications on health outcomes, the decisions we make when it comes to habitat protection and restoration could be the difference between life and death for these species. I want to be a good doctor who can safely practise and work collaboratively with patients to achieve good outcomes, but I want the same when it comes to ecological issues.

I am determined to somehow bring together the world of the hospital, where there is too much artificial light, noise, and sanitisation, and the natural world with its strange creatures and untidiness. I just cannot quite figure out what that should look like, which might be the source of my frustration and occasional sense of isolation.

Like Arlo Leopold, Douglas Adams addresses the seeming hopelessness of our predicament and describes loneliness. But he takes another angle, turning to point towards those seeking to maintain the cracks of hope that brighten our lives on earth.

There is one last reason for caring, and I believe that no other is necessary. It is certainly the reason why so many people have devoted their lives to protecting the likes of rhinos, parakeets, kakapos, and dolphins. And it is simply this: the world would be a poorer, darker, lonelier place without them.

Douglas Adams - 'Last Chance to See'

As I interact with this world, I ask myself how I can make it richer, brighter and more thoroughly communal. Sure, I was that climate kid, but I am 24 now, and tired of the same circular conversations about the depressing state of the world. I do believe marrying medicine and ecology can offer us a way out of this loop.

As for the cognitive dissonance necessary to function at a day-to-day level without disintegrating... Sometimes obscenely wasteful practices are standard medical protocol. Sometimes my actions will contravene my environmental values. And I have to be okay with that.

So long as I keep sight of my anchor, and push hard for the environment at the right moments, I think I can accept the short-term discord as necessary. I won't get lost in the swell. And I hope I can hold you there with me so that caring no longer brings loneliness, but solidarity instead.

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A CASE FOR TRANSCRANIAL MAGNETIC STIMULATION

SAMUEL DIPROSE

Since 2008, Transcranial Magnetic Stimulation (TMS) has been saving lives in South Australia. But, only for patients who can afford it.

Whilst the Adelaide Clinic, a private psychiatric hospital in Gilberton, has been offering this treatment for over a decade, it has yet to be embraced by our public health system. The science of depression is important, but often it is not science that determines public policy, it is emotion. With that in mind, let me tell you a story.

The day you walk into your GP's office when your symptoms are not in your throat, heart, or lungs, but instead your head, is really hard. The doctor asks what brings you in, ready to inspect your tonsils or take your blood pressure, but that is not what you need today. There will be no physical exam or imaging requested, and yet the illness you present with kills thousands of people every year.

That first appointment is a very important step in the journey towards getting well.

Maybe you start with some Sertraline or another common antidepressant, perhaps a referral to psychology or maybe even both. And for many, this is the solution. The results will not be immediate, but for many, this is where their interaction with depression will resolve.

When the patient goes through this process without success, and their symptoms only get worse, so too does the often-overwhelming feeling that "this" may never end.

Back to the GP, maybe your SSRI dose goes up, or maybe you try another. Still no improvement. The diagnosis is no longer major depressive disorder (MDD), it is now treatment-resistant major depressive disorder.

Next is probably a couple more antidepressants, at high doses. With this comes a higher side-effect burden. Then, your primary medication will be augmented with another antidepressant or even lithium. Maybe you try an older class of medication such as a tricyclic antidepressant, with even more side effects.

For a patient who has still not responded, it is time to think about neurostimulation.

In South Australia, this is also the stage where the patient's income can very much impact their quality of life over the next few months.

For a long time, electroconvulsive therapy (ECT) has been the gold standard treatment for depression. It achieves remission in up to 90% of patients, depending on the study. ECT is a lifesaving treatment. I can say that because in 2021 it saved mine. That said, it is also quite a tough thing to go through. It involves many sessions of a general anaesthetic, a seizure and then time to recover.

For a portion of the patient cohort, ECT will always remain the treatment that saves their life. But for many others, there is an option that will achieve remission from depression without having to go through such a significant procedure. The answer is Transcranial Magnetic Stimulation.

TMS is a treatment modality indicated for treatment-resistant MDD which also falls into the bucket of neurostimulation. Thinking back to the GAMSAT briefly, perpendicular to a magnetic field runs an electric field, and this is how the treatment stimulates the brain. The difference to ECT though, is that the current is smaller, targeted to only a specific site of the brain, and most importantly, below the seizure threshold. This means no anaesthetic, no seizure, and no hospitalisation. It is an outpatient treatment.

To be clear, TMS will never completely replace ECT. Some patients will still require ECT. What TMS will do is divert a significant portion of the cohort who require neurostimulation away from ever progressing to ECT, and the benefit for those individuals will be absolutely worth it. The literature suggests TMS works for somewhere between 50-60% of patients where medication had failed.

The trouble is, in South Australia at least, TMS is not offered by the public health system. Over 450 public patients have ECT each year, and none of those have the opportunity to receive TMS first.
Since 2008, the treatment of depression in South Australia has had two tiers. If you were lucky enough to afford private health insurance, you could access TMS. If you could not afford it, then your options were left to either ECT or suffering without ever reaching remission.

We need a psychiatric system where treatment is determined by need and need alone. Like many things, a patient's quality of care still depends on their income. That is not okay.

It is time to establish a Transcranial Magnetic Stimulation Unit in our public health system.

'DISCOMFORT AND GROWTH'

NOUR ALSALEM

Moving around has become a normality in my life. I have lived in England for ten years, then returned to my motherland, Kuwait, for five years, and heading on for five more here in Australia. From moving to different schools, to switching between cultures that were worlds apart, one thing stuck with me throughout the years. I had to be okay with being uncomfortable amid great change.

After living alone for the first-time last year, I came to realise that I had to adapt to all the new responsibilities that were handed to me overnight. Organising bills, booking my own appointments, getting my own groceries, going to the first day of university alone. Yes, these may seem like the simplest of tasks to some, but for a newly 19-year-old living eleven thousand kilometres away from home, those felt like the biggest hurdles. Nevertheless, I passed all those hurdles. What seemed like the biggest challenge at the time is now merely a part of my daily tasks.

The thing is, I not only overcame those hurdles, but I gained the most knowledge and skills from them.

I learned that I could rely on myself. I learned a new favourite hobby that I would have never discovered if I let the dread of social anxiety overpower me. I learned more social skills than I ever could have if my parents were around to guide me every step of the way. I learned that my mind was the sole thing preventing me from so much of my potential. I learned to adapt and find my own way through what felt like a new world to me. These skills not only increased my eagerness to try new things, but they also opened opportunities for things that would have never crossed my mind. This truly is a powerful tool as it applies to various aspects of your life, including your relationships with yourself and others, as well as your faith and career. In the end, it's a personal experience for each person to live and discover for themselves and I look forward to experiencing new opportunities and self-growth in relation to my hobbies, career, relationships, and life in general.

Wiest (2017) mentions that as human beings we seek comfort because we physiologically associate it with survival. We tend to hold back sticking to familiar things, rather than grow and discover the discomfort that comes with uncertainty. For me, I found that I had to alter my mindset to push past this and think of the alternative positive outcome rather than the embarrassment or judgement of others. We will never find out what our true potential is until we try something foreign. This discomfort is what allows us to thrive and excel in ways we never imagined. If we stay within a safe and comfortable corner living in fear of uncertainty, we will never see the inconceivable reality waiting for us.

Every small discomfort will inevitably bring you closer to the best parts of yourself that have yet to be revealed. Whether it's a change as small as booking your own appointment for the first time to taking a completely new path in your career, take the uncomfortable risk and see where it leads you and what unexpected opportunities arise.

I strive to stay ambitious and optimistic no matter how many times I may be put down by either my mind or others for I'll never know what my true potential is until I try. Just try.

If I hadn't changed my mindset towards pushing through discomfort, so much of who I am today--let alone writing this--would have been buried and never discovered. I thrive through this discomfort; it's funny how you learn a whole new world about yourself.

NOUR ALSALEM

South Australian Salaried Medical Officers Association

JOIN US NOW!

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

Run by salaried doctors, for salaried doctors, SASMOA stands up for young doctors' rights in the workplace.

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

SASMOA

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FREE FOR STUDENTS!

Check out more online at sasmoa4doctors.com.au

Standing up for the pay, conditions & wellbeing of SA's young doctors

The health and wellbeing of the young doctors working in our hospitals is a key focus for SASMOA.

That's why we are campaigning on a new **TMO CHARTER DEVELOPED BY OUR TMO COMMITTEE** which outlines the minimum standards we believe are needed to create a 'well workplace' for young doctors.

In the past 12 months we've won increased job security for Trainee Medical Officers, via longer minimum contracts (up from one year to three years after your intern year). We've won a requirement that rosters be issued with 4 weeks notice, so you can actually plan your lives outside of work, and that your base pay will be paid every fortnight, regardless of timesheets.

There's much more to do — and we can only do it if salaried doctors stick together, via the Salaried Medical Officers Association.

Join now — it's never too early to get organised.

SCAN THE QR CODE TO READ THE FULL CHARTER NOW

South Australian Salaried Medical Officers Association

TMO CHARTER

Minimum standards for a well workplace for TMOs

Safe Work:
I perform jobs that are within my training, capacity and experience, and my workplace has appropriate resources and staffing.

Safe Hours:
When I work, I work hours which are safe and reasonable.

Breaks During Shifts:
I have breaks during my work shifts that allow me to leave my immediate workplace and have uninterrupted time to eat, revitalise and refocus.

Breaks Between Shifts:
I have a guaranteed 10-hour break between my work shifts, providing enough time to allow me to rest and recuperate.

Work Space:
I have the time and physical space at work to do paperwork and to study.

Rosters:
I can plan my life, knowing at least 28 days in advance when I will be required to work.

Leave:
I can take leave to which I am entitled when I need it. I am afforded flexibility when I need it to care for my loved ones, myself, or to study.

Life Outside Work:
I have opportunities to connect socially within and outside of medicine and work.

Pay:
I am paid accurately and on time.

Mentoring & Training:
I am supported by a manager/leader who provides mentorship, coaching and appropriate supervision. I have opportunities, resources and supports to learn and grow professionally, and to satisfy training requirements.

Respect:
I am treated with respect and dignity, and know that if I am not, or if I am discriminated against, I can report it confidentially and timely action will be taken.

Consultation:
I am asked about my views and needs in the workplace, and am listened to when decisions that affect my life at work are made.

Feeling Valued:
I am recognised for my contribution, and appreciated for my work.

Peer Support:
I am supported by a team of peers, with whom I have time to reflect and debrief.

Wellbeing Support:
I have access to supports including mental health and wellbeing supports in the workplace, and I know who to ask for help should I need it.

Developed and endorsed by the **SASMOA TMO Committee** and **SASMOA State Council**

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