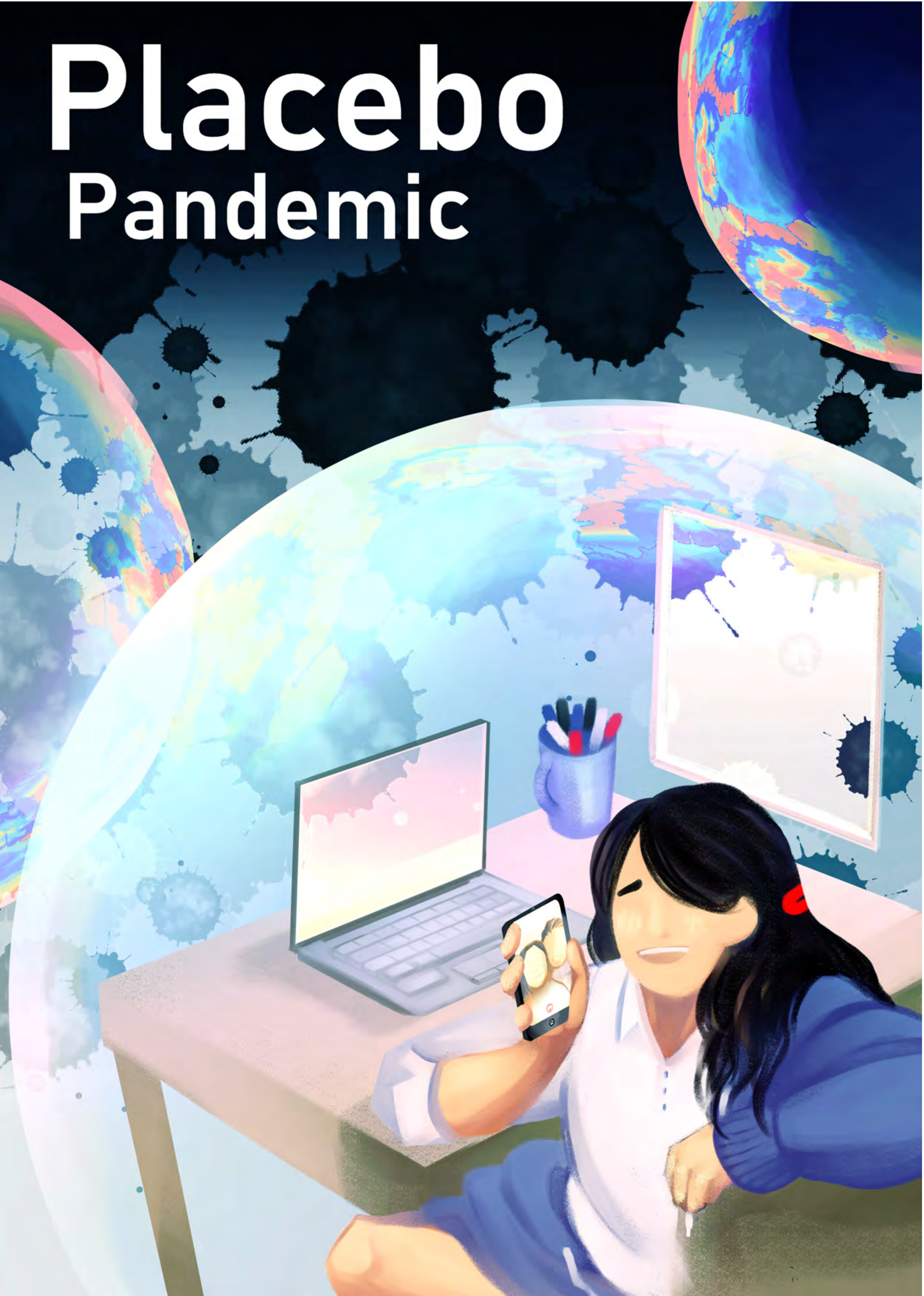


Placebo
Pandemic

Contents

4 PLACEBO PRESIDENTAL FAREWELL
7 FOREWORD
8 EDITORIAL
10 INTERNING WITH WHO?
15 HAVE WE DEVELOPED 'GREATER GOOD' FATIGUE
17 CONSENT, CONVENIENCE OR CONSUMER-CENTRED CARE
22 "THESE ARE UNPRECEDENTED TIMES."
24 ONE ROO APART
27 PRCC(OVID19)
30 FINDING EMPATHY FROM DARKNESS
33 COVID IN A DEVELOPING COUNTRY
35 THE SPANISH FLU
39 LGBTQIA+ HEALTH IN MEDICAL EDUCATION
40 WHAT ARE YOU WEARING?
41 COGITATIONS ON OUR QUEST TO FIND A SILVER LINING IN THE SHROUD OF THE ....
44 "MEDICALLY BLONDE": A TALE OF IDENTITY, LOVE AND MEDICINE
46 MEDREVUE TESTIMONIALS
48 WRIGHT EVENS MEDBALL 2020- IN THE JUNGLE
50 AMSA NATIONAL CONVENTION 2021 COMES TO ADELAIDE

President Farewell

President Farewell

Undertaking the role of President for FMSS was challenging for me in many different ways, the role is diverse and requires a range of skills and attributes. There is the advocacy side, which I would best describe as careful listening and measured and camouflaged anger. There is the social side, which I have probably over-indulged in. As President you have to maintain the professional identity of FMSS, we won't discuss MedCamp or the behaviour I am sure I will exhibit at MedBall or Grad Ball. Then there is space for your own spin on the role, spending your time and utilising the ears that listen to you because you're the student body president. It's a little odd to be honest, if you have imposter syndrome its sure to over-activate. I did, and still constantly find myself in between measured confidence and debilitating self-doubt… but that's showbiz baby.

The landscape of the Flinders medical program is vastly different from when I began 4 years ago. We had a taste of the old style, the PBL and block exams and then we were swiftly rushed into the PAL system and PT. Unfortunately for my year level and those that followed, I witnessed the impact of PT on the culture of the medical cohort. The result being that assessment modalities that are dependent on students failing decimated student collegiality. In retrospect it was incredibly saddening to see fractures form in my cohort and clouds of uncertainty and competitiveness affect many relationships. However, as overly dramatic as it may seem, the revision of PT marking methods this year, in my opinion, will do much to save student culture. It will change the rhetoric and for students commencing next year hopefully reinforce their sense of collegiality and togetherness. I am really proud of the fierce advocacy. Matilda and I headed up on this issue and is one of the wins I will take away with me from this role.

There are of course other issues that still require the devotion of time from special students. Including the under representation of different groups in our society in the medical curriculum. Including LGBTQIA+ peoples, sexual health including sex worker health, refugee health, domestic violence and continuing emphasis on Aboriginal and Torres Islander Health. It's difficult to adapt static curriculums to dynamic and diverse populations and I envision this will be a major challenge moving forward. As our medical knowledge continues to expand and our appreciation for the intersection of different social determinants grows it will become increasingly difficult to cram it into four years. But this is the role of the medical student body to continually challenge the medical education establishment and continue to fight for a degree that prepares us for the pluralistic societies we will serve.

As I leave Flinders I am filled with optimism and confidence that the degree will continue to improve in strides with new receptive leadership. The student body will continue to challenge the school and facilitate progressive changes in the program. The culture will continue to become more cohesive and students will begin to reclaim the collegial spirit that was once lost.

I have gained an enormous amount from my time at Flinders and as the President of FMSS. I hope that I have been able to commit and give enough back to reciprocate the personal growth I have been able to undertake. I owe so much to the student body who inspired me, supported me, aged me and made my time so meaningful. I am excited to watch many of you in the years to come and see the kind Doctors I know you will become.

Ciao for now x
Liam Ramsey
FMSS President 2020

OPPORTUNITY FOR NEW GROWTH
- QING HILL

Foreword

I present you Placebo: Pandemic, your second and last issue for 2020.

What a year. 2020 has been a tough year. COVID 19 and its impact has ranged from mild stress to a full-blown tragedy. How I have socialised has been limited, but this was for a good reason as collectively we sought to halt the propagation of what for some can be life-threatening. We've been fortunate in Australia to have such low fatalities relative to the rest of the world. Our isolated status here between the Indian and Pacific oceans meant that early and proactive measures could work. Across the globe, regions like Europe are reinstating measures that get a grip on their escalating situations. COVID 19 is likely to stay a part of the conversation when you'll be reading Placebo 2021. Sorry future editors, Pandemic is being covered here.

It's been fun putting these issues together for the readers. I raised my hand back in November last year eager to bring a different vision for what Placebo can be. It was a learning journey so I am extremely appreciative of my marketing counterparts Harrison and Josh, who have been very forgiving as I stumble my way through making Placebo. I've made mistakes (sorry Yuze and Brandon) but hope overall this magazine has been a pleasure to sit down and flick through whilst in the common room. I wish all the best to the next team responsible for making this magazine.

Lastly, I wouldn't have achieved anything if it wasn't for the generous contribution of your peers who wrote for Placebo. I'm so grateful that they gave their time to put their thoughts on paper.

Editor Ramy Robin

Contributors

Patricia Carlisle
Abby Dawson
Rod Evans
Joyce Haddad
Jayda Jang
Elizabeth Koh
Huy Le- Tran
Lawson Lim
Nicholas Loh
Gowri Manesh
Christine Mausolf
Megan McKeough
Alen Pasalic
Nicholas Pavic
Liam Ramsey
Syeda Amel Safi
Felicity Shepherd
Caitlin Skinner
Tracey Smart
Paul Thalivasal
Ysabella Tyllis
Brandon Wadforth
Shannon Waters

FMSS also acknowledges the Kaurna People, the traditional custodians of the land on which Placebo is produced. We recognise their continuing connection with their country and pay respect to Elders both past and present.

Word from the front cover designer Elizabeth Koh

In the early stages of this pandemic, it was very heartening to see that many responded to the loss of physical socialisation by reaching out even more. The only thing we could do early on was limit our contact with each other in the hope that we'd slow the dissemination of infections. Yet so many people checked in on loved ones more, or sought ways to help out in their community, and connect to their fellow humans. It's just really nice to know that despite not our physical isolation, we have continued to connect with and be there for each other.

Editorial

I lived in Adelaide for many years before starting at Flinders. I've been lucky enough to be able to maintain my social connections and regular pastimes during my medical studies. This was something I appreciated because, don't take this the wrong way but I struggle to hang around medical students all the time. I appreciate having these social circles so I can take a break from medicine sometimes. They help me unwind and get out of the med student mindset. Only this year, did I learn that a surprising number of them had rather extreme views on health.

I was aware that they looked favourably on alternative health practises, but COVID set their imaginations alight, and I see them now moving from odd to outlandish belief systems. Each day, they share sensationalised articles. I feel personally attacked when they use personal heroes of mine like Jim Halpert and Dwight Schrute from The Office, in memes to describe me as mindless sheep and naïve. I once mustered the courage to reply to one of these posts, where someone I knew was disparaging the measles vaccine as a disaster and asserting that any COVID vaccine would be similarly unsuccessful and dangerous. I pointed out that the measles vaccine has actually been a huge public health success. In response, I was criticised for not 'trusting my immune system' and being duped by big-pharma.

I don't think it's because they are lazy or malicious, but rather that they lack the understanding of what makes good research. They believe credibility comes from the effort they put into the research, rather than the quality of the research itself. No one likes having their research or belief system questioned, but it's particularly difficult when one believes that they are champions of truth protecting the public against powerful vested interests.

The voices used to support their views are eclectic, to say the least. The supposed whistle-blower claiming financial compensation for nursing homes reporting false COVID cases. The relationship between 5G networks and the rise in COVID like a sickness. Somehow, they always find some source that echoes or distort a narrative to match the view they already had. Yes, Dr Fauci did advise against masks back in March, at a time where there were concerns hospitals didn't have enough. But it is clearly misleading to extrapolate this into a view that masks are actually harmful and quite a massive leap to use this to claim

that they are a tool for globalists' control and domination.

These friends of mine now feel that they are victims of censorship and suppression. This is where I am torn, in that I do think they have some right to say what they'd like. Even if they so irresponsibly promote fictitious stories and willingly present material with such contextual distortion. My value in free speech doesn't go so far as to think hate speech is permissible, but this isn't that, this is just thoughtless speech. There is a worry though that their promotion of such false material could cause harm, that's where many social media platforms have drawn the line on freedom of expression. Their blatant disregard of health advice, believing it an infringement of their freedoms, can undo all the work we've done to stop the spread. Paradoxically, in some kind of self-perpetuating cycle, the more Facebook or Twitter moderate their posts, the more driven they are in their commitment. Even my good mate (not really) POTUS has been flagged for false comments and that's made him very mad.

If we weren't amidst a pandemic and concerned that they may contribute to a second wave, perhaps we might be more willing to let them rant.

Consider the interactions before this Pandemic when medical professionals had to defend vaccines. Is infinitely better to empathise with anti-vaxxers, rather than belittle them, and that only dialogue might convince them to meet us halfway. With a good doctor-patient relationship, they might yield their unfounded beliefs partway. One doctor last month told me they had convinced a family who worried about vaccines and autism to give their newborn vaccinations after eighteen months, a compromise that might save their life later. That doctor put pride aside and refrained from confronting these parents about their ideation. They took the win.

While acquaintances of mine daily accuse the broad medical profession of being complicit in the erosion of their freedoms, I must remember not to take their attacks personally. I'm just very careful to not mention my degree when around them, and maybe after a few years, I might post a photo of myself with my expensive piece of paper and graduation gown. The COVID deniers I know might finally learn I'm aspiring to be a doctor and see me as one of those big pharma loving mindless sheep. A 'covidiot'. I'd hope instead they'd remember that I wasn't that bad. In the meantime, I'll just keep managing this uncomforta-ble situation.

Written by Ramy Robin

Interning with WHO?

Working in Switzerland at the headquarters of the World Health Organisation amidst the largest public health event of our time isn't an experience anyone can plan for. Joyce Haddad found herself in this position when she started her internship in February. Joyce is a Flinders Alumni and PhD candidate, with research focused on nutrition and public health. Joyce left Australia for her position in February. By the 11th of March 2020, the WHO declared COVID-19 a pandemic. I reached out to Joyce Haddad fascinated by what an experience this must have been.

– Ramy Robin

My role at the World Health Organization was within the newly established Department of Nutrition and Food Safety, in the Unit of Multisectoral Actions in Food Systems, which aims to support Member States in reducing the burden of diseases caused by unsafe food, unhealthy diets, and malnutrition in collabo-ration with UN partner agencies, international organisations and stakeholders.

Part of my role was supporting the WHO COVID-19 Nutrition and Food Safety Working Group. Once the pandemic was declared, we were inundated with queries, as member states, organisations worldwide and media sought guidance on a very wide spectrum of issues related to COVID-19, nutrition, food safety and health. To me, this pandemic really highlighted the key role food and nutrition has across many sectors. From harvesting issues to the safety of wet markets, and protection of seasonal food system workers, through to mana-gement of food fortification programs, and food assistance at refugee camps. There were questions about food trade and virus transmission, and if breastfee-ding with COVID-19 was still safe.

This is a novel virus – so during the height of the pandemic, we were learning, and simultaneously informing the world. With many countries in lockdown, unsure of what would happen next, it was not only Ministries of Health, but media and the public who were turning to WHO for answers. Great care was taken to ensure the most accurate information was provided, to maintain credi-bility in such an unprecedented time.

The focus of my work shifted as the pandemic unfolded. The COVID-19 pandemic highlighted and exacerbated the limitations of the food system, inclu-ding its inequities, its fragile supply chains, its high toll on the planet's resour-ces, and the lack of resilience to shocks. From local food systems to global insti-tutions like the United Nations, many have been calling for radical structural change to ensure everyone has equitable access to nourishing food. It is crucial to avoid going back to "business as usual", as this would mean more of the same disasters, including intensification of non-sustainable agricultural and animal production; destruction of natural ecosystems; increased risk of zoonotic disea-ses emerging and spreading to the human population, as happened with COVID-19; higher levels of malnutrition; and the continued rise of diet-related *diseases*

Governments need to appreciate that the food system needs an overhaul. Policies must be developed to build and maintain much more sustainable food systems. Key policies, like agricultural subsidies, need to be re-orientated away from harmful practices and towards incentives to produce sustainable, safe, healthy, and nutritious foods. The conversations about transformational change need to happen and keep happening, allowing everyone, everywhere, to imagine and demand a more equitable, nourishing, and regenerative food system. We need to stop commodifying food and value it again.

How we tailor and deliver health communication is of particular interest to me and the focus of my PhD studies. Any person passionate about evidence--based health and/or nutrition knows how challenging it is keeping up with the confusing and contradicting fads, which are usually communicated by non-ac-credited personalities. As health professionals, the challenge is mainly getting our voices heard amongst all the differing opinions that currently exist. Simulta-neously, health professionals themselves have different approaches to commu-nicating health. Every approach can be justified - health is not black or white and perspective must always be taken into account. So I hope that health profes-sionals can work towards a unified and harmonious attitude, respecting diffe-rent professional perspectives, so that we can avoid adding to confusing public health messages.

My research focuses on establishing the need for tailored, digital public health nutrition messaging. Personalised nutrition holds a lot of promise in improving dietary behaviours, and technology allows us to integrate personalisa-tion into dietary intervention trials on a large scale. The evidence on the effecti-veness of communication and messaging to improve dietary behaviour is limited. I have merged multiple research streams together to find the efficacy of digi-tally delivered tailored nutrition messages on the dietary behaviours of Austra-lian adults. The fact that digital technology can be harnessed in multiple ways to improve population health and wellbeing is very exciting. Apart from efficiency and convenience, using the internet to deliver evidence-based nutrition and health advice to a large number of people holds promise for advancing public health efforts through research and policy.

By Joyce Haddad

CONCEPT OF ENVIRONMENTAL CARE FOR OUR PLANET-GAJUS

URBAN PADDOCK Co.

COFFEE . GRAB & GO FOOD . SNACKS | THE HUB, FLINDERS UNI BEDFORD PARK

Complimentary
Income Tax Returns
When it comes to handling your finances, Wright Evans Partners provide simple solutions to help you invest, grow and protect your wealth throughout your career.
Which all starts with a complimentary income tax return! Call us today to book your appointment.
wright evans partners
23 Greenhill Rd, Wayville, SA, 5034
p | 08 8208 4777
e | info@wepartners.com.au
www.wepartners.com.au

Interested in mental health?
Considering a career in psychiatry?
Looking for more information?

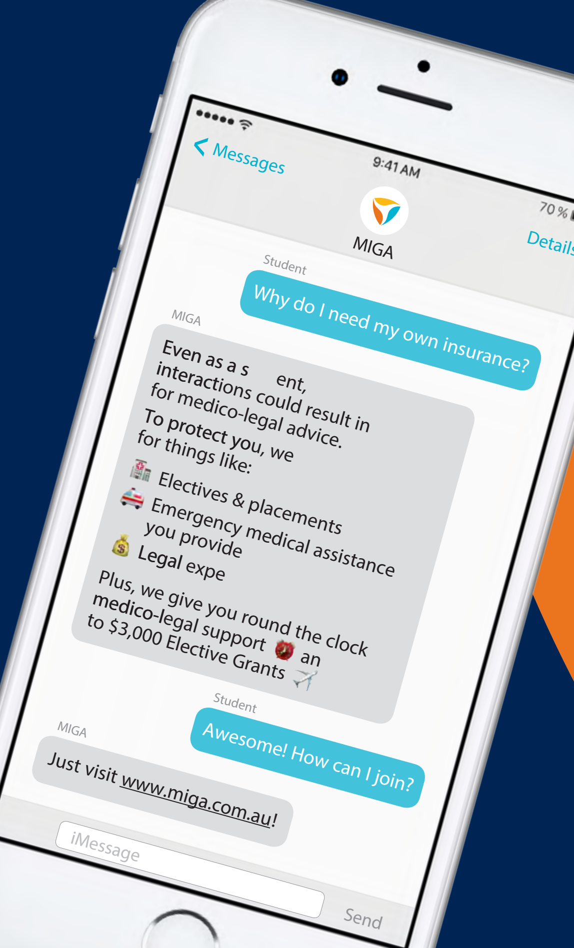
Join the Psychiatry Interest Forum (PIF)

www.ranzcp.org/pif

Membership is free and benefits include:

- invitations to educational events
- career guidance and networking with RANZCP Fellows and trainees
- scholarship and grant opportunities
- access to the RANZCP e-learning hub
- e-newsletters to keep up to date with RANZCP activities

Protect yourself with FREE medical indemnity insurance for students



What are you waiting for?

Joining online is easy – visit our website today!

www.miga.com.au

Insurance policies available through MIGA are issued by Medical Insurance Australia Pty Ltd. MIGA has not taken into account your personal objectives or situation. Before you make any decisions about our Policy, please read our Product Disclosure Statement and consider your own needs. Call MIGA for a copy on 1800 777 156 or visit our website. © MIGA April 2018

Have we developed 'Greater Good' fatigue?

Written by Air Vice-Marshal (RET) Tracy Smart

In Early August I watched the Four Corners program on the Melbourne COVID-19 outbreak. It laid out the flaws in the system, both the pre-existing issues and the many points of failure, that contributed to the outbreak. But amongst this analysis, two quotes stood out for me. The first was Professor Raina McIntyre who, in laying out the case for hard hotel quarantine for overseas returnees, got to the crux of the matter - that we needed it because "We can't rely on everyone to do the right thing". The second was from besieged Victorian Premier Daniel Andrews. As the outbreak spread and he contemplated putting the entire city under Stage 3 restrictions, he made a plea to the public: "The government cannot do this on our own. We need every Victorian to play their part".

My conclusion was that the reason we needed strict quarantine in the first place was that we can't trust people to rise above their self-interest and do the right thing; we also couldn't trust people to do the right thing in the quarantine situation; and that when we needed the public to play their part in stemming the outbreak they didn't, on the whole, rise to the challenge. So, while there were systemic failures, there is also a fundamental problem with people understanding and behaving in a way that benefits the 'greater good'. In other words, the problem is us.

Public health 101 says that in order to control a pandemic, everyone must play an active role in protecting and preserving the health of the public. It's in the name! And yet after a very good start, the people of Victoria and many others right across the country have failed at these basics. The question is why? Why is it that, when threatened with a major unfolding disaster, such as last summer's bushfires and the early days of the pandemic, we all respond with an extremely strong sense of community, but now seem to be motivated by self-interest? Are we suffering from "greater good fatigue"? I think the answer is that our modern western society has evolved to put too much emphasis on the individual above the collective; the 'me' above the 'we'.

It didn't seem like that when I was growing up in a small country town. Here the sense of community was strong and it was the norm to prioritise things that would benefit all. I then entered military service where again it was the expected that we put serving the nation above our own needs. But things have changed across the broader Australian society. We live on the fringes of Asia, where collectivism rules, but we are more heavily influenced by our distant neighbours across the Pacific and to the north, where individualism triumphs. Individualism works for many people in good times. After all, it's the key to 'American exceptionalism' and the 'American Dream'. But even in the best of times, it leads to a widening inequality gap and in a public health crisis, it's an absolute disas-ter. For evidence, just look at the contrasting performance during the pandemic between most countries in Asia and the US.

To not only survive but thrive in a global pandemic, we need to return to this sense of community. It's not easy to do in such a slow-burning crisis but if not now, when? And just how do we harness all that 'greater good' menta-lity that is on show during an imminent disaster and extend it to get us through this period in history? I think we start with going back to the principles we clung to during the bushfire crisis and in the early days of the pandemic. These are: look after yourself; stay connected with family and friends; help those who need help; support local businesses; put the health NEEDS of the nation above your individual WANTS; stop looking for someone to blame and the government to tell you what you should do; act responsibly; and above all, be kind. If we collec-tively reset our mindset to the community over self, we may just end up with a better society in the longer term.

I have been pondering how our culture can empower us to overcome this greater good fatigue. Can we draw from our strengths and sense of purpose to not only bind together in this time of crisis but to role model for others what strong communities look like, even though we have been splintered to the four winds for much of this year? Tweaking our culture to help us thrive while living in this strange new COVID world is no doubt a great challenge, but one I look forward to working on. I have recently taken up an academic role at the Austra-lian National University where I will spend the coming months in my new role as Public Health Lead for their new COVID Response Office. But it will take communities everywhere, both those who have returned to their regular lifes-tyle and those still working and studying from afar, to effect this change, and I would love for you to consider how we might best do this.

BALCONY CONCERTS
- CATHERINE CORDASCO

Consent, Convenience or Consumer-Centred Care

How Will you Shape your Clinical Practice?

The current pandemic has revealed much about our humanity and calls into question what we value as individuals, families, and communities, near and far. While there are sobering examples of sacrifice, selflessness and positive signs for optimism, it is also tinged with equal measures of deep sorrow, hardship, and flagrant selfishness. There has been an opportunity to slow down, pause awhile and reflect on the values that influence our lives. An opportunity for each of us to contemplate upon, possibly for the first time, who we are and what we hope to become.

As medical students faced with the challenges that lay before you, never have the opportunities been so significant, and never have they been so daunting. Witnessing to the strength and perseverance but also the fragility of the human spirit, demonstrated in the community you serve in an era of economic rationalism, requires a greater focus on knowing the ethical, legal and professional tenets of medicine. Each of you will be called upon to understand and act from these foundational principles in ways that support your clinical models of care. Foundational to these principles is the wise maxim to 'know thyself'. Succinctly, who are you, how will you be and what will you become in your practice of medicine? Your responses can provide the impetus of your vision and your vision statement for your personal and professional prac-tice.[1] Crucially, how does your clinical practice reflect who you are and how you will advocate for those you have commi-tted yourself to serve? How do you want to be remembered?

Is there a Role for Law in Shaping and Supporting your Clinical Practice?

The suggestion posited throughout this brief paper is that an understanding of the essential laws and professional ethics that governs your medical practice can make you are an adept, communicative, and confident medical practitioner. The knowledge and practice of medical or healthcare law and professional ethics does not supplant your clinical knowledge but rather, complements it. An opening comment in the recently updated 'Good medical practice: a code of conduct for doctors in Australia (Code of Conduct, (2020)) identifies that the Code, 'support[s] individual doctors in the challenging task of providing good medical care and fulfilling their professional roles, and to provide a framework to guide professional judgement'.[2] Furthermore and importantly, the Code of Conduct (2020), 'is not a substitute for the provisions of the legislation and case law. If there is any conflict between this code and the law, the law takes precedence'.[3] On the other hand, recent reviews of this updated edition have drawn some criticism to this proposition.[4] However, and not diminishing this critical distinction, the discussion arose in the context of doctors who spoke out about the deplorable conditions in immigration detention centres. A genuinely polarising and specific area of law distinct that poses serious questions for healthcare practitioners though it sits outside the scope of this discussion. This paper reviews the well-established laws governing consent and refusal of medical treatment within the hospital and community setting of South Australia (SA) and the Northern Territory (NT).

Controversy and Debate

Several articles were published from 30 September to 1 October 2020, relating to leaked South Australian documents about how doctors ought to manage their referrals within the healthcare system.[5] The articles outline how a senior SA Health manager emailed surgeons that provided

1. A potent concept suggested to me by my wise mentor was to write a personal and professional epitaph reflecting the life I wanted to live and the approach that honoured that vision. Crucial to this imagining is, how do you want to be remembered.
2. Medical Board(Ahpra), Good medical practice: a code of conduct for doctors in Australia – October 2020; includes link to latest edition of the Code. Updated on 1 October 2020 from the 2014 version.
3. MBA Code of Conduct (2020), section 1.3.
4. AMA, 'Updated Medical Board Code of Conduct' (9-October 2020) https://ama.com.au/articles/updated-medical-board-code-conduct
5. Isabel Dayman (30 Sept 2020), https://www.abc.net.au/news/2020-09-30/manager-urges-surgeons-to-say-no-to-older-sicker-patients/12717132; Isabel Dayman (1 Oct 2020) https://www.abc.net.au/news/2020-10-01/leaked-emails-reveal-sa-health-ageist-culture-cota-says/12722480; Matthew Dooley (1 Oct 2020) https://www1.racgp.org.au/newsgp/professional/public-servant-asks-surgeons-to-say-no-to-gps (each formally accessed 20 October 2020).

'advice' or suggestions about how to manage consumer treatment, including: tighten up [y]our processes with regards to incoming referrals … we also expect that where the person is old or has many comorbidities, you might suggest to the GP that is [sic] not necessarily in their best interests … Please use your wealth of consultant experience and start to say 'no' when clearly not sensible and high value care [is warranted].[6]

The responses from a range of stakeholders were swift and critical of the imputations, that were defended as unintentional, misinterpreted, and contextual. Dr David Pope, SASMOA President, stated it was inappropriate and indeed 'unethical' for a medical administrator to direct how doctors were to practice.[7] At the same time, Dr Chris Moy (AMA Vice President) described the language of the email as 'clumsy'.[8] The Chief Executive for the Council on Ageing, Jane Mussared, described the email as 'pure and simple ageism'.[9] Noteworthy is that the same [female] administrator released a later email avowing the importance of consumer-centric care. The issues are complex, multi-layered, and complicated by the challenges confronted by communities across the world dealing with the economic impacts of COVID-19. The most vulnerable communities and those requiring the most significant level of advocacy are the defenceless, disenfranchised, the minority groups. These are issues that existed before the pandemic and amplified as a result of it. However, is there more subtle substance attached to this email, explicitly or implicitly? Moreover, have the issues about who this is about and what values we wish to adopt in our society been displaced or hidden within the convenience of an economic downturn driven by COVID-19? The ramifications of COVID-19 pose an enormous concern to be sure, but does this leaked document reflect a message more pervasive and more sinister that is developing within our communities, our vulnerable and ageing SA and NT communities? I will leave the reader to review these articles and to reflect upon the complex legal, ethical, and ethical-professional issues they raise for how doctors may practice medicine. Instead, I will overview some of the primary legal considerations when deciding how to act, or not act, as the case may be in issues around consent and refusal of medical treatment, which is fundamentally associated with referrals of medical care.

Principles in Law Governing Consent to and Refusal of Medical Treatment

What remains consistent in the world of medicine is the constancy of change. Whether the decision is to act or not to act, those decisions are governed by the same legal and professional-ethical principles. The facts of the consumer's current status and their historical medical journey are generally the basis upon which a doctor will direct their clinical management plan. However, a discussion that does not balance the consumer's perspective is overshadowed with paternalism. If we consider the essential principles governing consent and refusal of medical treatment as two of the most prevalent examples in healthcare delivery, these principles can become the most misunderstood, particularly in complex situations. Furthermore, understanding the fundamental principles are essential before the advent of voluntary assisted dying into SA law which is currently only a validly legal option in Victoria.[10] Firstly, '[f]or consent to be valid, it must be informed, voluntary and made with appropriate decision-making capacity. To ensure consent is fully informed, the patient should be provided with sufficient information relevant to the decision at hand'.[11] Consent is based upon four common law principles: capacity (commensurate with the decision at hand), voluntary choice freed of coercion and undue influence (including from doctors), covering the specific and agreed upon treatment, that is informed with a broad explanation that provides adequate information on the relevant risks and consequences of the treatment specific to that consumer (CVCI).[12] Furthermore, criteria 3 and 4 are reinforced in the SA legislation under the doctor's 'duty to explain'.[13]

6. Isabel Dayman (30 Sept 2020), https://www.abc.net.au/news/2020-09-30/manager-urges-surgeons-to-say-no-to-older-sicker-patients/12717132
7. Isabel Dayman (30 Sept 2020), https://www.abc.net.au/news/2020-09-30/manager-urges-surgeons-to-say-no-to-older-sicker-patients/12717132
8. Isabel Dayman (30 Sept 2020), https://www.abc.net.au/news/2020-09-30/manager-urges-surgeons-to-say-no-to-older-sicker-patients/12717132
9. Isabel Dayman (1 Oct 2020) https://www.abc.net.au/news/2020-10-01/leaked-emails-reveal-sa-health-ageist-culture-cota-says/12722480
10. The Voluntary Assisted Dying Act 2017 (Vic).
11. Australian Medical Association - AMA Code of Ethics (2016), footnote to Patient Care 2.1.4.
12. Hunter and New England Area Health Service v A (2009) 74 NSWLR 88, [26], [29]-[30], McDougall, J.
13. Consent to Medical Treatment and Palliative Care Act 1995 (SA), section 15. While this section (serves to support other legal principles as well), it reinforces the importance of criteria 3 and 4.

The principle of refusal raises anxiety and misunderstanding when the decision of the consumer is in opposition to what the doctor believes is in the consumer's best interests. Remembering, however, that '… the legal requirement of consent to bodily interference protects the autonomy and dignity of the individual and limits the power of others to interfere with that person's body'.[14] Recognising that capacity, (in fact each element of consent, 'CVCI') acts as the gatekeeper to the exercise of those autonomous ethical rights where merited. In accord with these sentiments are the consumers' right to consent to refuse treatment. Well established in Australian law is the understanding that:

an individual of full capacity is not obliged to give consent to medical treatment, nor is a medical practitioner or other service provider under any obligation to provide such treatment without consent, even if the failure to treat will result in the loss of the patient's life.[15]

Furthermore, this law is maintained 'even if a refusal may risk permanent injury to [their] health or even lead to premature death'[16] and, 'does not have to be sensible, rational or well-considered'.[17] A concluding comment in this brief gallop through consent and refusal of medical treatment is the centrality of trespass to the person, which is the liability that arises in matters based on consent, or lack thereof:

It is the central thesis of the common law doctrine of trespass to the person that the voluntary choices and decisions of an adult person of sound mind concerning what is or is not done to his or her body must be respected and accepted, irrespective of what others, including doctors, may think is in the best interests of that particular person'.

Are the doctor's clinical knowledge and experience key in developing medical care plans suitable for the specific consumer? A resounding, yes! However, it is only the first part of the collaborative discussion. Enter the specific consumer or their nominated substituted decision-maker and their consent or refusal is paramount to their right to participate in their own healthcare. The doctor's common law duty of care, 'is a single comprehensive duty to exercise reasonable care and skill in the provision of professional advice and treatment'.[19] Fundamentally, 'the care of your patient is your primary concern',[20] and to do so within your scope of practice.[21] Furthermore, to also implement a 'suitable management plan'[22] that considers a 'balance of benefit and harm in all clinical-management decisions'.[23] Therefore it remains a balance. The doctor and consumer work collaboratively towards the given proposed outcome (in theory and practice). It is a balance of interests that better served by developing a therapeutic relationship that is based upon mutuality, trust, and respect, each for the other. Therefore, it is not an either/or proposition, it is not a one-directional and top-down process affected by the indoctrinated cultural mores of paternalistic medicine or paternalistic governments. It is not an administrative imperative to minimise the economic burden of a burgeoning healthcare budget against the value and respect for all members in the community, particularly the most vulnerable. It is consent to treatment, not convenience to consent with which we are dealing. It must remain so and, opening to newer visions of how that operates within a community with specific demographics within the broader context of COVID-19 and the challenges it poses for individuals, families, communities and the social institutions that manage them is a current priority.

---

14. Secretary, Department of Health and Community Services v JWB and SMB (1992) (Marion's Case) 175 CLR 218, 309-10, McHugh, J.
15. Brightwater Care Group (Inc) v Rossiter [2009] WASC 229, [26], Martin CJ.
16. Re T (adult: refusal of medical treatment) [1992] 4 All ER 649, 664, Donaldson, L.
17. Re T (adult: refusal of medical treatment) [1992] 4 All ER 649, 664, Butler-Sloss, LJ.
18. Secretary, Department of Health and Community Services v JWB and SMB (1992) (Marion's Case) 175 CLR 218, 309, McHugh, J.
19. Rogers v Whitaker 175 CLR 479, 489 cited in Wallace v Kam [2013] HCA 19, [8].
20. MBA Code of Conduct (2020), section 3.1.
21. MBA Code of Conduct (2020), section 3.2.1.
22. MBA Code of Conduct (2020), section 3.1.2.
23. MBA Code of Conduct (2020), section 3.2.4.

Final Words

Understanding the basic legal principles supports, not impedes, a doctor's practice of medicine that respects the consumer's autonomous rights to choose or refuse treatment. The focus must always remain on the principles underpinning those choices and decisions. Neither government 'administrators', nor doctors can adequately decide how and why a consumer ought to consent to or refuse treatment. However, what is essential to any therapeutic relationship is that the appropriate options are explored openly in an honest, transparent, and respectful way. Failing to refer where necessary, overriding a person's legitimate right to choose or refuse treatment is anathema to a consumer-centred care, and indeed healthcare delivery. It is and must remain, a collaborative decision between doctor and consumer, requiring skilful communication underpinned by a healthy dose of empathy and understanding. It is, and always has been, a consumer-centred focus of care. It can be accomplished when the doctor's knowledge and experience are supported by the principles of law and professional-ethical codes and regulations, that standardises clinical practice.

Re-envisioned healthcare delivery involves the merging (not clashing) of the minds and the openness to a vision that can re-imagine that clinical healthcare delivery, in association with knowledge of the law, can enhance healthcare delivery options that supports all members of the community. The law remains a valuable tool in the bag of resources available for the clinician to practice medicine in a consumer-centred, legal, ethical-professional manner. The words of bioethicist, lawyer, and doctor, Emeritus Professor George Annas remain central to these sentiments:

> *Law remains interwoven with the practice of medicine, as it was in the 19th century. Physicians who do not have a basic understanding of the law are … at a distinct disadvantage when practising medicine. The evolution of medical jurisprudence into health law over the past two centuries has been dramatic [and] equally consequential are the ways in which health laWw issues are framed and the legal forums in which they are resolved.*[24]

Opening your eyes to the influence of law in the practice of medicine will remain a frivolous aspect of medical curricula, and remain objectionable in clinical practice until there is the willingness and vision to embrace and respect each highly regarded profession, aimed towards delivering a consumer-centred framework of healthcare.

Patricia Carlisle
Lecturer, College of Medicine and Public Health
Teaching Specialist (Academic)
22 October 2020

24. George J. Annas, 'Doctors, Patients, and Lawyers — Two Centuries of Health Law', (2012) 367, 5 New England Journal of Medicine, 448.

Keep on learning

Dr Russell Thompson
MDA National & RDAA Health Bursary
2018 Winner, Intern

MDA National member since 2018

Providing medical indemnity insurance and expert medico-legal advice since 1925. Free cover and membership for medical students is just one way we help you to progress your career.

Join for free
mdanational.com.au — 1800 011 255

MDA National Insurance products are underwritten by MDA National Insurance Pty Ltd (MDANI) ABN 56 058 271 417 AFS Licence No. 238073, a wholly owned subsidiary of MDA National Limited ABN 67 055 801 771. Please consider your personal circumstances and read the Important Information and Policy Wording at mdanational.com.au before deciding to buy or hold any product issued by MDANI. AD367

"These are unprecedented times."

By Syeda Amel Safi

We have heard this phrase countless times in the last few months. Unprecedented... so much so that, even in the face of disaster and chaos, when our lives and understanding of the world has been thrown into disarray, we are expected to behave in an unprecedented way. Everyone around hopes, and whispers in understanding that any outlash, and irrational behaviour is understandable, but in that same moment, they turn and say, "keep going". The world keeps turning, but people want their normal back. We want to go back to before, despite our better judgement and experience, despite knowing that things change, and cannot remain the same.

We are facing more than one global crisis right now; COVID-19, Black Lives Matter, climate disasters, mental health. Even just one of these things is enough to destroy lives. As they have already destroyed countless lives. Yet the world continues, universities continue, people continue.

Let's take a moment to be real here.

Are you really okay? In the face of a global crisis, you may be living as you normally do, maybe things haven't hit you as bad as others. But can you really sit there and say with confidence, "yes I am okay, I am doing well, I am handling this unprecedented time"?

If any of you sitting there and feeling panic, anxious, or overwhelmed, let me tell you; you're not the only one, your feelings are normal, they are valid, and we are all not okay. We are being forced to push through the unusual circumstances, we are being told "please take care", but the resources to help us take care of our health, of our mind, are often out of reach.

We are walking around with minds overflowing from anxiety and chaos. We have thoughts and feelings, but with everyone feeling overwhelmed and lost, how can anyone find the path back to serenity?

How many phone calls and appointments does it take, to get a session with a psychologist? The answer depends on whether it is covered under insurance, whether there are availabilities within or outside of typical hours, and whether you can find the right person. Consider that it costs about $200+ per counselling session; to get there, a referral from a GP is needed, and you may need to call and see if your insurance covers mental health "extras". Some of us can make use of the government's ten partially subsidised sessions, but what about our international peers? The government recently increased the number of subsidised sessions to twenty, but that action is more akin to putting a Band-Aid over a gushing wound, than an actual resolution of growing mental health concerns.

One of the growing barriers, especially in rural and remote health, is availability of these services in a timely manner; there are simply too few adequate health professionals to cater for the population demands. It will take at least one

- LILY BANSE

call to your GP, possibly one to your insurance company, and one to your new therapist to try and book a session. Three calls, and many days in between. You need to gather the courage to take a step forward for your sake, at least two times, and that's only in the best-case scenario. Let's consider the cultural, and socio-economic sensitivities of one's mental health. If your therapist is not culturally competent, all that courage, all those steps forward, everything that was built, can all be shattered by just a few words, in a few minutes. If your therapist is simply not available for the next several months, then you're fresh out of luck and have to fight to stay afloat the best you can. If you can't afford the cost of therapy, then you won't even be able to consider the services you need.

Unprecedented times. Doesn't mental health always make the times unprecedented? It has always been difficult to get help. Now it feels impossible. Help is not just a call away. Help is hours away, and we are bleeding out. We need more than just awareness; we need to go beyond breaking the stigma. There is so much work to be done to ease accessibility, to improve global mental health, but before anything can be done, we need to work on ourselves first.

Let's get better, then, let's get to it.

Tangy eucalyptus wafting with zing
Meddling magpies swooping poor sods in spring
Kookaburras cackling in the gum tree
What more could this well-worn trail throw at me?

Cascading Third Falls signals end is nigh
Yet look more closely with an eagle eye.
Basking in warmth, a kanga and her roo
Sight seen many a time, but like anew.

Alas, Skippy reminds us heart-to-heart
Of the yellow caution sign at trail's start:
Keep at least one adult kanga apart.
Amidst corona, a fair price of admittance
'Tis worth the hike heeding social distance.

By Huy Le-Tran

BECOME A SPECIALIST GP

Become exceptional,

WITH GPEx

Specialised education and expert training for doctors who choose to specialise in General Practice.

Talk to us about training toward a Fellowship of the ACRRM and/or a Fellowship of the RACGP on the general or rural pathways or as a rural generalist.

Contact GPEx to learn more about GP training and choosing your pathway.

1300 473 972 gpex.com.au

SPECIALISED EDUCATION AND EXPERT TRAINING SOLUTIONS FOR GENERAL PRACTICE IN SOUTH AUSTRALIA

Image: Dr Cristina Valero, Medical Education Fellow (GPEx GP registrar 2017-2020).

We know you're working towards more than just a piece of paper

Realising your potential isn't just about qualifications.

We've been working with medical professionals for over 30 years and we know the passion and commitment that will sustain you over a long career of caring for others.

Our Student Banking Package has been designed to help support your journey, every step of the way, long after you've celebrated your graduation.

Visit **boqspecialist.com.au** to find out more.

BOQ Specialist. The bank for medical professionals

The issuer of these products and services is BOQ Specialist - a division of Bank of Queensland Limited ABN 32 009 656 740 AFSL no. 244616 ("BOQ Specialist"). Terms and conditions, fees and charges and lending and eligibility c riteria apply. Any information is of a general nature only. We have not taken into account your objectives, financial situation, or needs when preparing it. Before acting on this information you should consider if it is appropriate for your situation. You should obtain and consider the relevant terms and conditions from boqspecialist.com.au before making any decision about whether to acquire the product. BOQ Specialist is not offering financial, tax or legal advice. You should obtain independent financial, tax and legal advice as appropriate. We reserve the right to cease offering these products at any time without notice.

PRCC(ovid19)

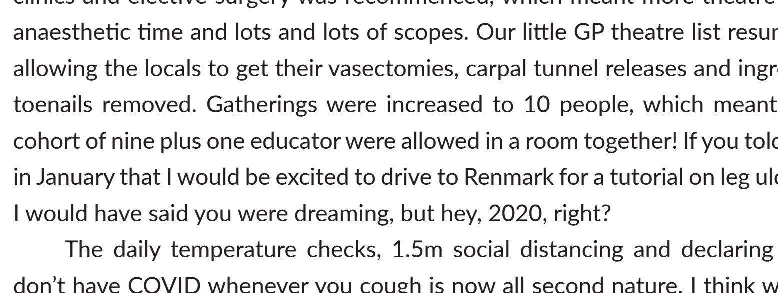
Picture this. You've finally made it to the clinical years of your medical degree. You're smashing goals - you've moved to a new town for rural placement, integrated into the community (which has meant spending a hefty amount on a netball uniform) and started placement at the local GP clinic. You can cannulate with one hand and insert a catheter with the other, blindfolded. You're delivering babies, intubating patients in theatre and managing STEMI's before their MedSTAR retrieval. You're the Riverland's new local hero, nothing can bring you down, you're on top of the world. You turn on the news. ScoMo is running a press conference. COVID-19 is here, Australia is in Lockdown. What was meant to be 10 months of fantastic clinical experience, unlimited learning opportunities and a year away from the dreaded car park 1/overflow situation is now an unforeseen future of uncertainty, MS Teams, Collaborate and Zoom.

While some elements of this story are grossly exaggerated (you decide which), this is roughly how the month of March went down for me in Loxton and my fellow PRCC students in the Riverland. It was an extremely strange time and just like everyone else, we had no idea what to expect.

So, what was it like being a PRCC student during a pandemic?

This answer depends on the individual. I was particularly lucky during COVID, as I wasn't removed from my clinic or forced to stay home. My consulting days increased in number as I no longer had specialist theatre or anaesthetic sessions. Some students were reduced to one session a week or sent home, some were asked to wear scrubs and full PPE to their clinics. Our regular specialists stopped visiting the Riverland but very kindly continued online tutorials. The GP world saw an inundation of phone consults and our EDs became very quiet. Our Wednesday education days that would normally take place at the Renmark Campus went online, which included running through ALS simulations over Zoom (an interesting experience) and we were all asked to present a 10-minute speech about an element of the COVID Pandemic (because why not?). Netball and football were cancelled and those of us who decided to get our names printed on the back of our uniforms (me) had evidently spent all that non-refundable money on "what could have been". We were isolated away from our families, which was particularly hard on students with family across the border in Victoria and WA. Our fabulous PRCC staff organised regular Zoom catch-ups and even made Riverland-wide deliveries of gym equipment, board games and puzzles to keep us busy and stay sane.

Despite my complaining about online teaching, spending far too much money on the netball season that never happened and my lack of any social life (who has one during med school anyway?), my clinical experience has been invaluable. With all URTI symptoms going straight to the COVID clinic, I had more time to focus on some of the other things that you normally see as a Rural GP. Even with a pandemic, pregnant women are still needing their routine antenatal care and having their babies. Patients are still presenting with wounds requiring sutures and a tetanus shot, and there are still suspicious lesions that need removal or punch biopsy. People still need referrals for their imaging and specialist appointments, and unfortunately not even COVID can stop a STEMI or stroke from presenting to the ED. We have seen a steep increase in mental health problems due to social and work impacts, and frequent elderly community members presenting with long lists of problems who just need a chat.



Slowly but surely, things began to return to normal. We all returned to our clinics and elective surgery was recommenced, which meant more theatre and anaesthetic time and lots and lots of scopes. Our little GP theatre list resumed, allowing the locals to get their vasectomies, carpal tunnel releases and ingrown toenails removed. Gatherings were increased to 10 people, which meant our cohort of nine plus one educator were allowed in a room together! If you told me in January that I would be excited to drive to Renmark for a tutorial on leg ulcers, I would have said you were dreaming, but hey, 2020, right?

The daily temperature checks, 1.5m social distancing and declaring you don't have COVID whenever you cough is now all second nature. I think we've all officially mastered the "Five Moments of Hand Hygiene". We've all had one or two of those nasty swabs and our lucky little community hasn't been subject to any big outbreaks of COVID-19. And with MedBall postponed, Scrub Crawl cancelled and all other social events in Adelaide put on the backburner for 2020, we don't feel like we've missed out on too much out here!

Lessons learned

Being in a rural community during 2020 has opened my eyes to life as a Rural General Practitioner, as well as the limitations and challenges a community like Loxton is faced with during a pandemic. We have a 25 inpatient bed hospital with three outpatient emergency beds and one trauma/resuscitation room, staffed 24/7 by nurses. The hospital is run by the nine doctors who work in the local GP clinic, with one on-call GP responding to ED presentations. Everyone is in contact with everyone, almost every day. One positive COVID test among any of the health care staff in Loxton and the entire medical team is in quarantine for two weeks. Not to mention the potential spread this has on the community, who rely on just one team of health professionals for all their needs.

Despite these challenges, the sense of community I have felt living in a rural town during a pandemic is like nothing I've experienced before. People have continued to follow (frequently changing) restriction rules and everyone has stepped up and done their part to help care for the elderly, who were faced with far stricter restrictions than others. It did mean that most of my conversations with patients involved a "so what do you think about this virus thing?" or "any cases in the Riverland yet?", but the repetitive conversation may just be a price to pay for a healthy community.

I have been incredibly lucky to spend 2020 in Loxton. The teaching and support from our education staff and GPs are second to none, and I feel very privileged to have been welcomed into a wonderful new community for 10 months. While our social isolation was mildly exaggerated by the 2.5-hour drive back to Adelaide, you can't complain when you get to spend a 'study' day going kayaking with your mates or doing your GAP assessments while having a coffee by the beautiful river. And more importantly, the memories and relationships I've made this year are some that I know I will carry with me for a very long time and will certainly help shape my future career as a doctor.

By Ysabella Tyllis

Finding Empathy from Darkness

Mental health in the current pandemic has been a bit of a buzz phrase for various reasons. Unfortunately, most of that has been unhelpful hijacking, not considering the nuances and aspects that are causing distress for vulnerable populations. But there is another side that is less talked about, people who haven't experienced mental illness registering high levels of mental anguish and distress.

For people who have never experienced mental illness, the distress felt by social isolation sheds a light on the darkness people with mental illnesses experience and the isolation that people with disabilities and serious illness experience.

BALCONY CONCERTS

It's harder to empathize with people when we have no experience with their suffering. Evolutionarily, we avoid pain. But in this instance I would urge you to lean in, to sit with those uncomfortable feelings. To remember them. To note the weight on your soul. And then, to look out and recognize them in others.

Brenè Brown talks about empathy. That to understand and experience empathy we have to open our own soul to the blackness of our pain, and to sit with the person suffering without trying to fix things. (Brown 2013)

Oh, as doctors we love to fix things. But I must tell you, there will be things you cannot fix. There will be suffering you cannot alleviate. There will be trauma you cannot undo. And there will be loss you cannot change.

And when you come to the end of medical knowledge and ability, what will make you stand out as a physician will not be cutting edge research and attempts to find a magic bullet. No, in our search for cures sometimes we lose sight of the patient. Not unlike the fictional Dr Jason Posner. (WIT 2001)

What will make you stand out is your ability to be with them in their deepest suffering. For you to see their fear and death with them. For you to face their demons with them. For you to be with them as they lose function and freedom. For you to walk with them through the valley of death.

My greatest memories of my doctor are when he held my hand as I walked through hell. Oh, it wasn't always tough. He made me laugh sometimes. But in the end, there are defining moments in our lives. And for me, those moments came out of the greatest suffering. Because hope's light shines brightest in the darkness.

By Felicity Shepherd

Consider looking at watching Empathy, by Brenè Brown https://www.youtube.com/watch?v=1Evwgu369Jw
Or WIT by Margaret Edson
https://www.amazon.com/Wit-Emma-Thompson/dp/B01MQMMROS.

- STEVEN WRIGHT

Avant student membership. By doctors, for doctors.

Sara Alamyar
Avant member

Free student membership and insurance with Australia's leading medical defence organisation

Your free student membership benefits include:

medico-legal advisers, available 24/7 in emergencies, to offer advice and support

evidence-based insights from our medico-legal experts, including case studies, videos, checklists and more

student eNewsletters and communications

opportunity to network and be part of the Avant Student Advisory Council

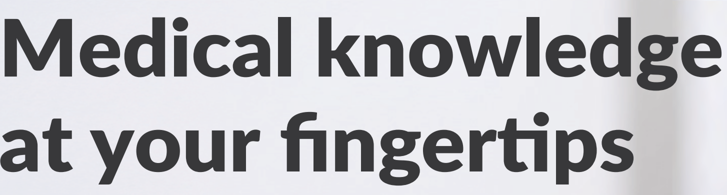
access to a unique student placement program with Interplast

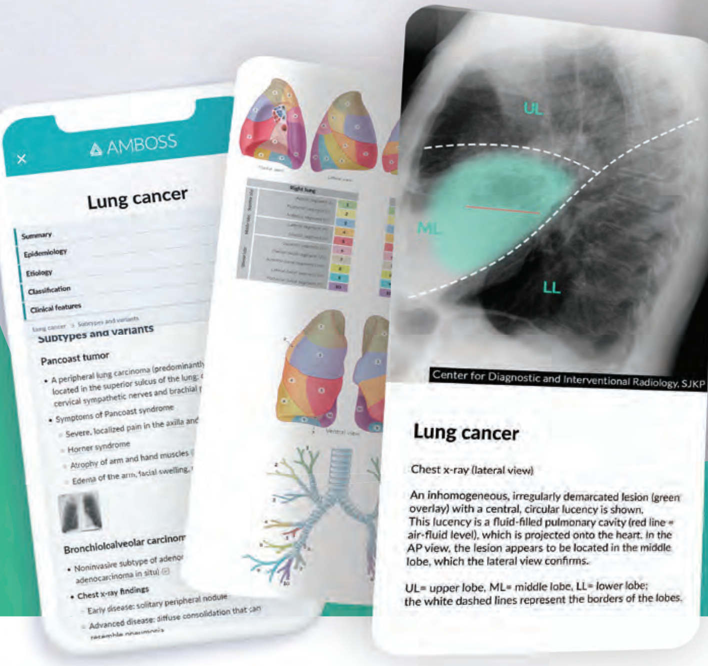
Sara Alamyar
Medical student
New South Wales

Join the medical defence organisation more doctors choose

1800 128 268
avant.org.au/student

IMPORTANT: Professional indemnity insurance products are issued by Avant Insurance Limited, ABN 82 003 707 471, AFSL 238 765. The information provided here is general advice only. You should consider the appropriateness of the advice having regard to your own objectives, financial situation and needs before deciding to purchase or continuing to hold a policy with us. For full details including the terms, conditions, and exclusions that apply, please read and consider the policy wording and Product Disclosure Statements, which is available at avant.org.au or by contacting us on 1800 128 268. MJN168 11/19 (0950.4)

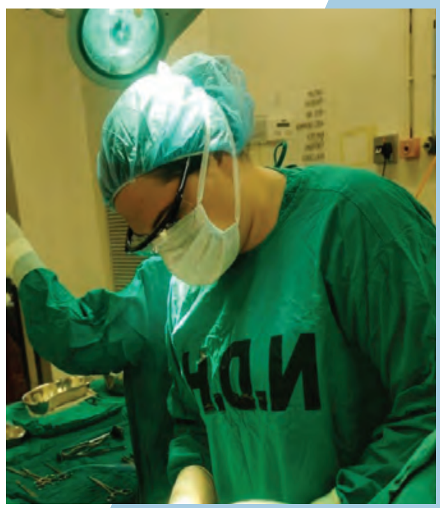




www.amboss.com

Consider COVID in a Developing Country

At the end of 2019 we travelled to South Africa for two-weeks of placement through the FGAP program. We were based in Bloemfontein, a rural city in the Free State province, with a population of around 550 000. We organised our placement with the help of Dr Johanna Jordaan, as she is originally from Bloemfontein, and we were placed in the National District Hospital, a public facility. We were under the supervision of various clinicians and working in multiple different disciplines. We weren't sure exactly what to expect at NDH, but from our experience we found that the hospital was grossly under-resourced, under-staffed and under-funded, and the majority of the doctors working there were less than three years out of medical school. Many of the situations we encountered were quite confronting. With the support of the doctors at the hospital, we were much more involved than we anticipated. We scrubbed-in on caesareans, helped with treatment in emergency, and spent many of our days assisting in, and learning about, the care of critically ill patients with HIV/AIDS and Tuberculosis. It was an intense experience to see such severely ill and dying patients, and also observe how patients, their families and the hospital staff dealt with these difficult situations on a daily basis. Additionally, we saw how poverty and inequality was largely to blame for these health issues, and also affected the subsequent level of care received by patients in the public system. Even though apartheid ended over 25 years ago, we could see the continuing impact it had on the country, with racial inequalities and separation still obvious, especially when comparing the patients accessing the private versus public healthcare systems.



During our placement we also had the opportunity to visit a private hospital and a military hospital, which we found were of a similar standard to public hospitals in Australia, and hugely different to NDH. We learnt that only 15% of the South African population can afford private health insurance, as the insurance costs similar to here in Australia, but the average wage in South Africa is dramatically lower. Consequently, the majority of South Africa's population only have access to the public health system, where access to primary health care is barely existent, and hospital resources and care is nowhere near the standard of the private system. Doctors at NDH told us that there is a three month wait for a CT scan, and that doctors often have to make the impossible decision about which patients they should fight for to try get an earlier scan. As you can also imagine, those who cannot afford private health care are from lower socio-economic groups, and therefore are disproportionately affected by diseases, meaning not only do they not have access to adequate healthcare, but that they are also the people who need it most. Despite this, we saw how tirelessly the staff at NDH worked to do what they could for patients with what was available, but we also saw the toll it took on them trying to care for patients without essential resources.

A few months after we returned from South Africa, the coronavirus outbreak had been established as a pandemic. Given our experience during our FGAP placement, we were extremely concerned for the people of South Africa. One of our supervisors on placement had spoken with us about how seasonal influenza outbreaks cause huge devastation amongst the large proportion of the population living in poverty and with conditions such as HIV, and the death toll from the outbreaks can be extremely high. Initially, South Africa had relatively low case numbers and went into stage four lock downs for 21 days. After easing restrictions, they experienced a surge of infections, with the highest daily case rate recorded in mid-July, at around 14 000 cases in one day. To date, they have 660 000 cases of COVID19, with 15 000 deaths recorded. However, it has been suspected that the actual number of deaths may be a lot higher than this, and we can definitely see how this could be true, given the under-resourced state of public hospitals.

This placement was an amazing opportunity and we feel very privileged to have had an experience like this so early in our medical careers. Those we met helped us remember what is truly important, and reminded us to appreciate what we have at home. We hope to return to South Africa, and its beautiful people, as soon as possible.

Written by Megan and Abby

THE SPANISH FLU

By Brandon Wadforth

The 1918 flu pandemic, caused by the H1N1 influenza A virus, is generally referred to as the Spanish flu. The Spanish flu began in February of 1918 and the astute reader will recognise that this coincides with the tail end of World War I (WWI), lasting from the 28th of July 1914 to the 11th of November 1918. 22.5 million people are thought to have died from WWI, including 8.5 million military personnel and 13 million civilians [1]. Conversely, in just one year, the Spanish flu resulted in the death of between 50 and 100 million people, although some estimates are as low as 21 million [2]. Furthermore, the majority of deaths from the Spanish flu occurred in a 16-week period. Clearly, at least in the early 20th century, the anthropogenic threat to human life paled in comparison to that of infectious disease.

The evolution of influenza viruses.

Influenza is a viral respiratory infection, and there are 3 major antigenic types of influenza: A, B and C. Notably, both influenza A and B are responsible for the majority of the morbidity and mortality; however, only influenza A yields pandemic potential due to its animal reservoir, particularly in aquatic birds and swine [3]. 'H' refers to hemagglutinin and 'N' refers to neuraminidase, of which 18 and 11 molecular types are known to exist, respectively. These surface glycoproteins are subject to both antigenic drifts and antigenic shifts [4]. Antigenic drifts are the product of small genetic changes resulting in a new strain of the influenza virus without a variation in the subtype, meaning the evolved virus may escape immune recognition. This is why we must vaccinate for the same virus annually. Alternatively, antigenic shifts describe a change in the H and N surface glycoproteins such that they become a new type ultimately establishing a novel influenza virus (i.e. a H3N2 virus may become a H1N2 virus). This occurs when a host is co-infected with 2 different influenza viruses simultaneously, allowing genetic exchange between the viral particles.

Why did the 1918 influenza pandemic claim so many lives?

The onset of this influenza virus coincided with a lack of antibiotics to treat secondary bacterial pneumonia, a frail and war-torn population, and an overstretched and underprepared health care system. Ultimately, this resulted in the abnormally high mortality. However, the 1918 influenza pandemic was categorised by 3 distinct waves, occurring in spring, fall and winter and the latter 2 waves carried a far greater case-fatality rate than the first [5]. So, with the aforementioned conditions being relatively constant, something had changed throughout the year that improved the virus' ability to take lives, and that change seems to be a series of virulence-enhancing genetic mutations [5].

A robust immune system is a good thing, right? Yes, undoubtedly. As it were, that didn't seem to be true in the year 1918. The 1918 H1N1 influenza was abnormal as it caused the death of many seemingly healthy individuals. This is not typical of influenza viruses, which generally claim the lives of the very young, the old and the immunocompromised [4]. Notably, this pandemic was not categorised solely by a young adult dominant mortality pattern, but rather a typical influenza mortality pattern seen in the vulnerable groups with a simultaneous increase in young adult mortality [6]. This creates a so-called 'W-trend', with mortality spikes for children, young adults and the elderly [7]. It is important to note that despite young adults representing half of the deaths from this pandemic, the case-fatality rate was still greater in the elderly population [8]. Thus, the excess young adult mortality was at least in part attributable to the disproportionately high influenza incidence in that group, however this does not explain the transition from a U-shaped mortality trend, typical of influenza, to a W-shaped mortality trend.

So, why is it that young adults were so vulnerable for this specific flu? Gagnon and colleagues [9] discuss 4 hypotheses which are all incomplete on their own; however, it would be unwise to assume there is a single answer for any mortality pattern. The concept of risk factors is a perfect example of this as it details that one's overall risk of morbidity or mortality is formed by the interaction of many individual factors rather than a single explanation. We shouldn't accept any single explanation for the excess young adult mortality seen throughout the 1918 influenza pandemic, but rather accept that these 4 theories may be pieces of the puzzle that to this day remains unsolved. The 4 major theories expressed by Gagnon and colleagues [9] include: inadequate exposure to previous influenza strains with similar antigenic properties for young adults and thus relative immaturity of their acquired immune system, a high prevalence of concomitant tuberculosis infections in young adult men, an overactive immune response expressed in the form of a cytokine storm due to the robustness of a young adult's innate immune system, and T-cell dysregulation occurring due to past exposure to the 1889-90 'Russian flu'.

Where did it all begin?

The Spanish flu must have begun in Spain, right? Wrong. The first record we have of this 1918 influenza virus in Spain is from an article published in El Liberal, a Spanish liberal newspaper [10]. The author said in that article "It's only the flu, sure. But the name doesn't make the thing." Indeed, an ironic outcome, the first article to be published in Spain questions the validity of titles and it was the very act of publishing that led to the 1918 influenza pandemic being titled the Spanish flu. Let me explain. Spain was neutral in WWI and, during times of war, freedom of the press is often restricted, allowing rage-inducing propaganda to flourish. The Spaniards were not subject to the same degree of political censorship as other countries during this time, allowing them more flexibility in commenting on the deadly influenza virus, ultimately creating a sense that they were the first people in the world to be affected [11]. To the best of our knowledge, the ground zero for the 1918 influenza pandemic was actually in Haskell County, Kansas [2]. We can learn from this. We should reserve certainty and hold a healthy scepticism about the first theory that arises describing the origins of a pandemic.

COVID-19 began in China, supposedly. Spanish flu began in Spain, supposedly. Of course, I'm not implying that Wuhan was not in fact the birthplace of our current pandemic, I am merely highlighting our past mistakes. We are indeed a far more advanced society today and communicable disease monitoring is much more reliable, potentially reducing the likelihood of mistakes, yet we remain susceptible to error.

Before we criticise outwardly, we must criticise inwardly. Say this virus truly began in China, that does not give us the privilege to blame. Can we really blame a country, a culture, a people for the acts of mother nature? If so, we must also blame for our own being, as genetic evolution facilitates our very existence. I have heard many blaming the cultural practices of Chinese people for the rise of SARS-CoV-2, claiming the Wuhan wet markets are the problem. We should not feel the need to blame a cultural practice for our own suffering. By now we should have evolved to a place where we can accept the wrath of mother nature without blaming a culture. Let's look inward for a moment. The Australian Strategic Policy Institute (ASPI) published a report earlier this year [12] describing the forced labour in China utilised by at least 82 global brands to provide us with the luxurious life we desire. These include Apple, BMW, Samsung and Nike. In a painfully ironic manner, I am writing this on an Apple computer right now. Clearly, our consumerist culture can be blamed for Chinese suffering, but we cannot see that. Rather, we absorb media on devices facilitated by forced labour that entitles us to belligerently criticise any culture other than our own. In the words of the author John Mark Green, "The self-righteous scream judgments against others to hide the noise of skeletons dancing in their own closet." The 1918 influenza pandemic should serve as an indicator of our past mistakes, and we should learn from them.

How did it spread so far?

The available evidence we have points to Kansas as ground zero for the 1918 influenza pandemic, which began on the 5th of March [13]. By the end of the month it had spread to several US military training camps, and throughout April had spread diffusely across the US, infecting both military personnel and civilians.

Simultaneously, US troops carried the virus to France and shortly after to Portugal and Spain. As aforementioned, the Spaniards publicised the endemic freely with their relative lack of political censorship leading to the adoption of the term 'Spanish flu'. Throughout June, the pandemic had spread further, infecting people across Germany, Scandinavia, Britain, Poland, Rumania, India, Australia, New Zealand and Indonesia. Despite the spread of the virus, the spring wave did not bear the same virulence as the fall wave, which was soon to arrive.

The fall wave possessed a superior virulence, with an increased likelihood of bacterial pneumonia superinfection at a time preceding Alexander Fleming's discovery of penicillin. First reports of this wave lead to a major Atlantic port in France on the 22nd of August, and the virus, contained in the lungs of returning passengers, rapidly spread across the US and Africa. Simultaneously, the virus spread all across Europe via military movement. Soon after, it was able to spread across the entire world through the railways and seas. Australia was largely protected due to careful quarantining. This was until early 1919, when the rise of the third wave coincided with the lifting of Australia's quarantine measures, leaving more than 12,000 Australians infected [7]. The virus then returned to the US and France and began to spread from there. This final wave ended around 6 months after its birth in Australia, resulting in more deaths than the initial wave but far less than the second.

As it were, most scientists at this time believed influenza was caused by the bacteria Haemophilus influenzae [3, 14]. In fact, it wasn't until the early 1930's that the American virologist, Richard Shope, isolated the influenza A virus in pigs. Despite this, they understood in 1918 that the most significant transmission route was via droplets and that diligent quarantining and isolation practices reduced community spread [7]. Furthermore, many countries had already established infectious disease mandatory reporting protocols. Despite such, the Spanish flu was not included on the list of conditions requiring mandatory notification until well into the second wave, at which point it was too late to isolate cases from the general public. To make matters more difficult, the conditions of WWI were not hygienic by any standard and diverting resources to public health in the middle of a world war may not be the most prudent decision. There were wounded soldiers to care for leaving a deficit in medical personnel back home. These considerations are truly just the tip of the iceberg, and it is no wonder why the outbreak was able to spread so far, infecting one-third of the world's population at the time, that is, 500 million people [8].

[1] Encyclopedia Britannica [Internet]. Chicago, Illinois, US: Encyclopedia Britannica, Inc.; c2000-2020. World War I: Killed, wounded, and missing; 2020 [cited 2020 Oct 09]. Available from: https://www.britannica.com/event/World-War-I/Killed-wounded-and-missing

[2] Barry JM. The site of origin of the 1918 influenza pandemic and its public health implications. J Transl Med. 2004;2(1). doi: 10.1186/1479-5876-2-3

[3] Saunders-Hastings P, Krewski D. Reviewing the history of pandemic influenza: understanding patterns of emergence and transmission. Pathogens. 2016;5(4):66-85. doi: 10.3390/pathogens5040066

[4] James SH, Whitley RJ. Influenza viruses. In: Cohen J, Powderly WG, Opal SM, editors. Infectious diseases. 4th ed. Amsterdam, Netherlands: Elsevier; 2016. p. 1465-71.

[5] Paulo AC, Correia-Neves M, Domingos T, Murta AG, Pedrosa J. Influenza infectious dose may explain the high mortality of the second and third wave of 1918-1919 influenza pandemic. PLoS One. 2010;5(7):e11655. doi: 10.1371/journal.pone.0011655

[6] Gavrilova NS, Gavrilov LA. Patterns of mortality during pandemic: an example of Spanish flu pandemic of 1918. Popul Econ. 2020;4(2):56-64. doi: 10.3897/popecon.4.e53492

[7] Martini M, Gazzaniga V, Bragazzi NL, Barberis I. The Spanish influenza pandemic: a lesson from history 100 years after 1918. J Prev Med Hyg. 2019;60(1):E64-7. doi: 10.15167/2421-4248/jpmh2019.60.1.1205

[8] Taubenberger JK, Morens DM. 1918 influenza: the mother of all pandemics. Emerg Infect Dis. 2006;12(1):15-22. doi: 10.3201/eid1201.050979

[9] Gagnon A, Miller MS, Hallman SA, Bourbeau R, Herring DA, Earn DJD, et al. Age-specific mortality during the 1918 influenza pandemic: unravelling the mystery of high young adult mortality. PLoS One. 2013;8(8):e69586. doi: 10.1371/journal.pone.0069586

[10] Davis RA. The Spanish flu: narrative and cultural identity in Spain, 1918. New York; Palgrave Macmillan: 2013.

[11] Trilla A, Trilla G, Daer C. The 1918 "Spanish flu" in Spain. Clin Infect Dis. 2008;47:668-73. doi: 10.1086/590567

[12] Xiuzhong Xu V, Cave D, Leibold J, Munro K, Ruser N. Uyghurs for sale. Canberra: Australian Strategic Policy Institue; 2020. 53 p. Report No.: 26/2020.

[13] Patterson K, Pule G. The geography and mortality of the 1918 influenza pandemic. Bull Hist Med. 1991;65(1):4-21.

[14] Van Epps HL. Influenza: exposing the true killer. J Exp Med. 2006;203(4):803. doi: 10.1084/jem.2034fta

LGBTQIA+ Health in Medical Education

Upon entering the world of medical education, I had a very optimistic view of it and how it would be taught. I had the assumption that medicine was progressive in all things, including social issues. Whilst this is true in some areas, I think that there is still significant progress that needs to be made for LGBTQIA+ health in medical education.

I have been fortunate enough to share the journey of one of my friends as they realised that they identified as non-binary. I am sure that this is a term that people have started to hear more of recently. For me, this meant supporting my friend in expressing who they truly are, and to utilise the pronouns that suited them - not me. I did not question this, not even once. I knew that caring for my friend meant that I would do whatever I could to make them feel more comfortable and safe. We as medical students and future doctors will also have this asked of us, not as friends, but as responsible doctors. Fundamentally I would like to think we are here to help people. Yes, this means knowing your stuff, but it also means approaching people as human beings. Who knew that the biopsychosocial model of health could be so important in being an effective doctor?

Pronouns and gender identity are just one example of why LGBTQIA+ health is fundamental in medical education. There are many unique problems that this patient demographic may present with. Also, you know what? These issues will apply for all specialities. LGBTQIA+ people are shown to be a vulnerable population in society and extend across all subgroups of our society. Some other specific considerations that come into play include increased substance abuse and suicide risk, STIs, urological and gynaecological issues or parenting, just to name a few.

There are plenty of different subgroups of society that we will treat as future doctors. Whilst it is unrealistic to expect that we will know every nuance of every community, you cannot ignore that people, our patients, have specific needs that must be considered for you to do your job as a doctor. Ask. Be open-minded. Advocate. We are all in a place of privilege as medical students and should strive for more than just learning about the biological approach to medicine.

I would love to see the school of medicine support its students to learn more about LGBTQIA+ health. HHRG present an amazing Inclusive Practice Night for us as medical students. However, this information needs to be built into the curriculum as an essential learning outcome for all students. This topic of LGBTQIA+ health in medical education is currently being assessed by a national study run by Melbourne University. As a medical student, you can be a part of this study and help inform universities to help drive this change. Please complete the survey by following the QR code, regardless of how you identify!

Written by Rod Evans

What Are You Wearing?

The Flinders University Critical Care Society's famed Dress Your Best initiative has a new, local focus for 2020. For those who haven't been confused by a cohort of post-graduates dressed in their faded Year 12 jumpers one Friday, allow me to explain: Dress Your Best invites MD students to dress to a theme on a Friday (Back to School, Hawaiian Shirts, you name it) for a small donation a chosen charity. Having now raised over $700 for donation to an FGAP-affiliated hospital in Tanzania, visited by previous FCCS committee members for placement, FCCS turned its attention to something closer to home, Sandpiper Australia.

Sandpiper Australia follows in the footsteps of Scotland's Sandpiper Trust. The Sandpiper Trust was founded in memory of Sandy Dickson, who passed away in a remote area of Scotland when emergency services could not respond promptly. Sandpiper equips rural clinicians with kits to attend these kinds of remote emergencies if required.

As someone born-and-raised in the city, I often take it for granted how lucky I am to live in proximity to an Ambulance Station with more than one vehicle and, a tertiary trauma centre staffed by world-class health professionals. Additionally, as medical students, we all know that where you live should not exclude you from access to high-quality medical care.

The Sandpiper Trust bags contain equipment that allows trained clinicians to deliver meaningful interventions when time is of the essence and distance is a seemingly insurmountable hurdle in reaching required care. To receive a Sandpiper Bag, a clinician has to adequate training in pre-hospital emergency management.

The Sandpiper Trust in the UK, partners with the BASICS Network, a network of general practitioners trained in pre-hospital emergency care who may attend emergency situations when requested. In South Australia, we have the Rural Emergency Responder Network, established under what was Country Health SA in 2009. However, this network has failed to take off nation-wide despite support from ACRRM and RACGP.

Sandpiper Australia is a charity that advocates for an establishment of an Australia-wide Rural Generalist-lead emergency response network like BASICS, with the standardised bag + training. Developing a cohesive network can improve the delivery of pre-hospital care for Australians living in rural and remote areas.

While the number of Dress Your Best events declined as a result of our COVID push for online learning, we hope that as face to face teaching resumes you will all keep on with the initiative every month for years to come. Leave those clinical clothes behind, once a month, and do it for a good cause.

Written byy Caitlin Skinner

Cogitations on our quest to find a silver lining in the shroud of the COVID cloud

Nicholas Loh, all correspondence to nicholas.loh@flinders.edu.au

INTRODUCTION

The onset of the COVID-19 pandemic has been life--changing. Some have even suggested (hopefully as a mature ego defence) that 'B.C.' should now mean 'Before COVID-19'! Although the basis for our calendars is unlikely to change anytime soon, the fact that people cast such remarks should indeed make us reflect on the sheer gravity of this crisis.

As of the time of writing, there are more than 40 million documented cases of COVID-19 and over 1.1 million COVID-19 fatalities worldwide. This is the most severe health crisis since the 1918 flu pandemic.

HOW I FIRST LEARNT OF SARS-CoV-2

On 31 December 2019, China informed the World Health Organization (WHO) of cases of idiopathic pneumonia in Wuhan, Hubei province. Who would have thought that those few cases would ultimately morph into the behemoth that we would stand against today?

I first learnt of SARS-CoV-2 in early January. As I am typing this, it amazes me that this was only nine months ago. Yet, it feels as though aeons have elapsed. When the academic year ended last November, I headed back to Singapore. During this period, I interned at the Ministry of Health. Around early-January, I started encountering news articles and YouTube videos on this peculiar outbreak in China. I thought to myself, "Surely this will be contained" and did not give it much further thought. How wrong I was. The "Wuhan virus" quickly became the talk of the office. Conversations across cubicles revolved around the virus.

Something had gone awry. These conversations were outlasting the regular news cycle that I was accustomed to. International news networks started to pay close attention to the situation. Soon, there was daily coverage on virtually every news network. Unfortunately, the virus had spread beyond Wuhan and into the rest of China's Hubei province Many other Chinese provinces were not spared either.

WHO declared COVID-19 to be a "Public Health Emergency of International Concern" on 30 January. Then, reports of the first cases and then tragically, the first deaths in many countries emerged. Eventually, on 11 March, COVID-19 was designated as a pandemic, and the rest is history.

CRUCIAL FACTORS THAT LIKELY FACILITATED THE RAPID AND WIDESPREAD TRANSMISSION OF SARS-CoV-2, AND COVID-19'S ABILITY TO INFLICT SIGNIFICANT HARM

Firstly, we should note that the initial critical period of the outbreak coincided with the Lunar New Year (which began on 25 January 2020[1], merely a few weeks after initial reports of the cases of idiopathic pneumonia), which is a significant period of the year in Chinese culture. During this period, people all over China typically go to great lengths (e.g. taking domestic flights, long train rides) to reunite with their immediate and extended families. It is thus reasonable to assume that this greatly facilitated the spread of the coronavirus.

Moreover, the spread of SARS-CoV-2 was likely exacerbated by the fact that Wuhan, the capital of Hubei province, has the reputation of being a crucial transportation hub within China. Significant Chinese metropolises such as Beijing, Shanghai, Guangzhou, Chengdu, and Xi'an (the site of renowned Terracotta Army; the capital city of Shaanxi province) are all situated within 1,200 km of Wuhan.[2]

Secondly, the R0, of SARS-CoV-2, falls within a 'sweet zone' which facilitates optimal transmission. R0, the basic reproduction number of an infective pathogen, may be defined as an epidemiological variable that denotes the number of cases generated by a single case throughout their infectious period in a population where all individuals are susceptible to infection.[3]

From the perspective of the infective pathogen, its evolutionary "goal" may be thought of as the attempt to infect as many hosts as possible and ensure that its genome can proliferate as far and wide as possible. With this paradigm in mind, let us consider some other pathogens before coming back to SARS-CoV-2. The genus Ebolavirus constitutes the notorious etiology of the Ebola outbreak in 2014. The case fatality rate for Ebola is notoriously abysmal, with the average Ebola case fatality rate in the 2014

rates of mortality, many hosts would die before being able to infect others. So, in a way, from the pathogen's perspective, being too deadly does not do will in rapidly proliferation in a given population. Unsurprising the estimated R0 of Ebola is relatively low: between 1.5 to 1.9.[5] Let us now consider another pathogen: measles virus, the most infectious pathogen we know of.

Measles is also known as rubeola, and it is particularly high-yield to not confuse this with rubella, which is unhelpfully known as German measles! There also exists, roseola, which is different from either rubeola or rubella. Be careful on the PTs!

Unlike Ebola, most people who contract measles turn out fine. While nasty sequelae of measles such as acute encephalitis and subacute sclerosing panencephalitis, the fortunate reality is that these sequelae are rare. Nevertheless, it is regrettable that there are still sporadic outbreaks of measles which are partly due to vehement anti-vaccine opposition by anti-vaccine groups, much to the detriment and misfortune of young and innocent children.

Measles is associated with aerosol transmission; measles viral particles can exist for up to two hours in an airspace where an infected person had coughed or sneezed.[6] Measles has an estimated R0 between 12 to 18.[7]

To put things into perspective regarding how infectious measles is, do you recall how we had to demonstrate immunity against various diseases when medical school started? Believe it or not, just being born before 1966 is considered acceptable evidence of immunity against measles. This is because the individual stand-alone vaccine for measles and eventually: the MMR vaccine, were only licensed for use around the mid-60s or shortly after. As such, being born before 1966 would practically guarantee one naturally-acquired immunity from measles.

Considering Ebola (relatively high mortality and relatively low transmissibility) and measles (relatively low mortality and very high transmissibility) as two ends of a spectrum, COVID-19 would fall somewhere between Ebola and measles in terms of both ease of transmission and associated mortality. Essentially, COVID-19 lies in the "sweet spot" of transmissibility such that it may inflict maximal harm to the maximum number of individuals. COVID-19 has an estimated R0 from 2 to 6 and is also notorious for the sheer variety of its presenting features in different patient populations.[8]

CONSIDERATION OF THE 1918 PANDEMIC, AND WHY COVID-19 MAY LINGER INDEFINITELY EVEN WITH AN APPROVED VACCINE

Under the COVID cloud, it is natural for us to look to the past for some idea of when things might "return to normal", whatever that means. One such event of the past that may reflect on is the 1918 flu pandemic (aka Spanish flu), which resulted in the infection of around 500 million people. At the time, this number of infected people constituted a third of the world's population and may have resulted in the death of anywhere between 20-50 million people.[9] Some estimates even suggest a fatality count as high as 100 million. This translates to around a 4-20% case fatality rate for the 1918 pandemic.

Contrary to what the eponymous "Spanish flu" might suggest, the flu most likely did not originate in Spain. What did, however, originate in Spain was news coverage of the 1918 pandemic. During WWI, Spain was a neutral country and provided news coverage of the 1918 pandemic in the initial period of the pandemic. As various news sources in Spain were essentially the only sources reporting on the pandemic, people started thinking that the 1918 pandemic originated in Spain.[9]

Fundamentally, the 1918 pandemic was caused by the H1N1 Influenza A virus (specifically the H1N1 IAV). This causative agent should ring a bell because it was also responsible for causing the more recent and better-known 2009 swine flu pandemic.

Interestingly, due to limitations in technology at the time of the 1918 pandemic (e.g. the disease-causing virus was too small to be visible under microscopes at the time), accurate diagnosis of influenza was a challenge. Haemophilus influenzae was instead thought to be the etiology of influenza because unlike IAV, the bacterium was large enough to be visible under microscopes of the time. Moreover, H. influenzae was commonly detected (likely to be secondary bacterial pneumonia) in many patients who had contracted influenza.[10] As such, a vaccine that was developed against H. influenzae reduced mortality rates despite not affecting infection rates.[11]

As we might tell from the name of the organism, the notion that Haemophilus influenzae was indeed the etiology of influenza was rather prevalent (hence the coined misnomer 'influenzae'). The binomen has unfortunately stuck, and even a century later, the unsuspecting student

may be misled to think that this agent causes the flu if he only blindly considers the pathogen's name!

So, what happened with the 1918 flu? Well, according to medical experts and historians, those who contracted H1N1 IAV developed immunity and things seemed to stabilise by the early 1920s. Reports of the time suggest that H1N1 IAV became less fatal as the pandemic tapered off into the background. Unfortunately, the H1N1 IAV subtype did not just fade into oblivion. The H1N1 IAV of the 1918 pandemic effectively mutated continuously, and as is characteristic of IAV: passed through humans and other animals. Descendants of the H1N1 IAV which caused the 1918 flu pandemic constitute the influenza viruses that we are battling today.[12] Even after smaller-scale pandemics arising in different regions of the world, flu shots are unfortunately still not completely effective at protecting people against influenza.

Currently, some political leaders have been noted to make rather controversial statements regarding the nature of COVID-19 and even provide possibly misleading assurances regarding when a successful vaccine would be released. Such misinformation can undermine both the public's trust in public institutions and hence the effectiveness of even the most immunologically successful vaccine.

Even if a vaccine is approved, there are no guarantees that it would be 100% effective. Relatively long-term side effects beyond the scope of clinical trials would not be completely known or understood. Let's not even get started on the issue of ensuring the equitable distribution of such vaccines. With all these issues at play, I frankly would be unsurprised if COVID-19 lingers indefinitely in the background like the flu, even with an approved vaccine.

THE POSITIVE THINGS THAT HAVE ARISEN POSSIBLY AS A RESULT OF THE PANDEMIC

Challenges offer new opportunities and encourage fresh perspectives for tackling problems. For example, "Zoom" have encouraged and simplified online teaching sessions, talks, and all sorts of events in the virtual world.

Additionally, I have heard from many friends how they enjoy having the flexibility of working from home. One particular cular friend mentioned how she could save so much time from not having to drive to work. She could have more sleep and take her time in the morning to prepare a drink!

Telemedicine is also another interesting thing to consider

It will be interesting to see how the doctor-patient relationship evolves as virtual platforms are increasingly embraced.

CONCLUSION

As we are shrouded by the COVID cloud, it is far too easy for us to miss the silver lining if all we expect is gold. A principle of governance comes to mind.[13] This applies to individuals just as it is for governments and companies:

Anticipate change and stay relevant.

Our expectations need to adjust appropriately (e.g. choosing to accept a lower salary, accepting a reduction in work hours). There might not be a rainbow with a pot of gold in sight, at least in the form that we had originally hoped. Nevertheless, a meaningful quest to find slivers of silver in the shroud of this cloud will have to suffice, as challenging as it is. After all, today's silver may just well be

1. EarthSky. Lunar New Year 2020 falls on January 25 Human World2020 [Available from: https://earthsky.org/human-world/chinese-new-year-lunar-new-year.

2. CTCS. Economic Profile of China's Hubei Province 2016 [Available from: https://www.tradecommissioner.gc.ca/china-chine/market-facts-faits-sur-le-marche/112025.aspx?lang=eng.

3. Fraser C, Donnelly CA, Cauchemez S, Hanage WP, Van Kerkhove MD, Hollingsworth TD, et al. Pandemic Potential of a Strain of Influenza A (H1N1): Early Findings. Science. 2009;324(5934):1557-61.

4. WHO. Ebola virus disease Fact sheet N°103: World Health Organization; 2014 [Available from: https://web.archive.org/web/20141214011751/https://www.who.int/mediacentre/factsheets/fs103/en/.

5. Khan A, Naveed M, Dur-E-Ahmad M, Imran M. Estimating the basic reproductive ratio for the Ebola outbreak in Liberia and Sierra Leone. Infectious Diseases of Poverty. 2015;4(1):13.

6. CDC. Transmission of Measles 2018 [Available from: https://www.cdc.gov/measles/transmission.html.

7. Guerra FM, Bolotin S, Lim G, Heffernan J, Deeks SL, Li Y, et al. The basic reproduction number (R 0) of measles: a systematic review. The Lancet Infectious Diseases. 2017;17(12):e420-e8.

8. Sanche S, Lin YT, Xu C, Romero-Severson E, Hengartner N, Ke R. High Contagiousness and Rapid Spread of Severe Acute Respiratory Syndrome Coronavirus 2. Emerging Infectious Diseases. 2020;26(7):1470-7.

9. HISTORY.COM. Spanish Flu 2010 [Available from: https://www.history.com/topics/world-war-i/1918-flu-pandemic.

10. Spinney L. Pale rider : the Spanish flu of 1918 and how it changed the world. London: Vintage; 2018.

11. WCaldbick J. Washington State Board of Health pessimistic about influenza pandemic in report to governor on January 1, 1919. 2017 [Available from: https://www.historylink.org/File/20313.

12. Amenabar T. 'The 1918 flu is still with us': The deadliest pandemic ever is still causing problems today: The Washington Post; 2020 [Available from: https://www.washingtonpost.com/history/2020/09/01/1918-flu-pandemic-end/.

13. Poon T. Governance in an Age of Uncertainty: How should public policymaking and

"Medically Blonde": A tale of identity, love and medicine

The perspectives of a writer

Alen Pasalic

This year's MedRevue saw our talented students come together to perform Flinders' most ambitious play, in unprecedented times. As one of the writers on the team, I thought I'd share with you our journey through the pandemic.

I joined the writing team because I wanted an outlet of expression. My time in medical school, like for many others, has been focused on my studies – namely, what are the necessary things I need in order to be a competent student and future doctor.

I didn't want these to be the only memories I had from medical school. Eventually, the hours spent in the library will blend into one amalgamated point-in-time; being a part of our community through avenues we love (in my case, script writing) will be the moments we remember.

In March, at the start of the project, we had nothing but a positive attitude and the fragments of a good idea – Legally Blonde, but with a medical twist.

Alongside 10 talented writers and friends, we made a script that explored strong moral concepts in an abstract way; the most apparent being identity.

Elle's character (acted out by the talented Mikayla Hussey) represented an exaggerated example of a student struggling with their self-worth and identity. Her value came in how she was seen by others, with respect to her pre-defined expectations of life and love. While not immediately apparent, I felt as though the foundations upon which her character was built became apparent when Elle lost what she thought defined her; her partner, friends and former life.

There's a point in the second act where we see Elle defeated:

"I don't think I'm cut out for this,"

Will I be good enough? Can I do it? I believe these are feelings we've all felt at different points in our lives – we wanted to show the audience they're not alone.

In came Emmett (perfectly embodied by MD3's Emerson Krstic), the voice of reason amongst Elle's loss. Emmet was the voice in my head that I wish was louder last year – at points when I really needed it. A voice telling me that I'm enough, reminding me of the opportunity I was given and that, with time, I will develop into an amazing, caring doctor.

"No one gets into this course because they are already a perfect doctor. As long as we are willing to work on our weaknesses and try again, we will get through"

Nowhere is Emmet's character epitomised more than in Minjoo Kwon's amazing remix of "Don't Worry, Be Happy".

Elle's perceived shortcomings were reflected against Vivian (brought to life by Angeline Seow) – the "perfect, smart girl that had everything [she] didn't" – and Warner (our final performance from MD4's Reid Amos) – a self-centred

that cared about no one but himself.

While Warner's villainy was clear, we wanted to demonstrate through Vivian the importance of self-acceptance. On the surface, Vivian represented the student that we wanted to be – academically flawless – but lacked the personality that made Elle so special. Through their dynamics, particularly approaching the end, we wanted to highlight how worthwhile we all are. Collectively we embody the industry, and we all have our place.

Appearance vs reality – embodied by characters Dr. Callaghan (dominated by Gabriel Patston-Gill) and Brooke Windham (vibrantly envisioned in Imogen Lee's final performance) – and the journey towards self-discovery were the foundations upon which the play was built around. Through our performances and work, we wanted to highlight the mindset, and concurrent growth, of a medical student.

During our productions, the unforeseeable happened – a worldwide pandemic that paused the world.

Selfish worries of whether I'll be able to see the musical in-person were being masked by terrible turmoil around the globe. Was I right to feel bad about the play potentially not being shown? or was I just thinking about myself?

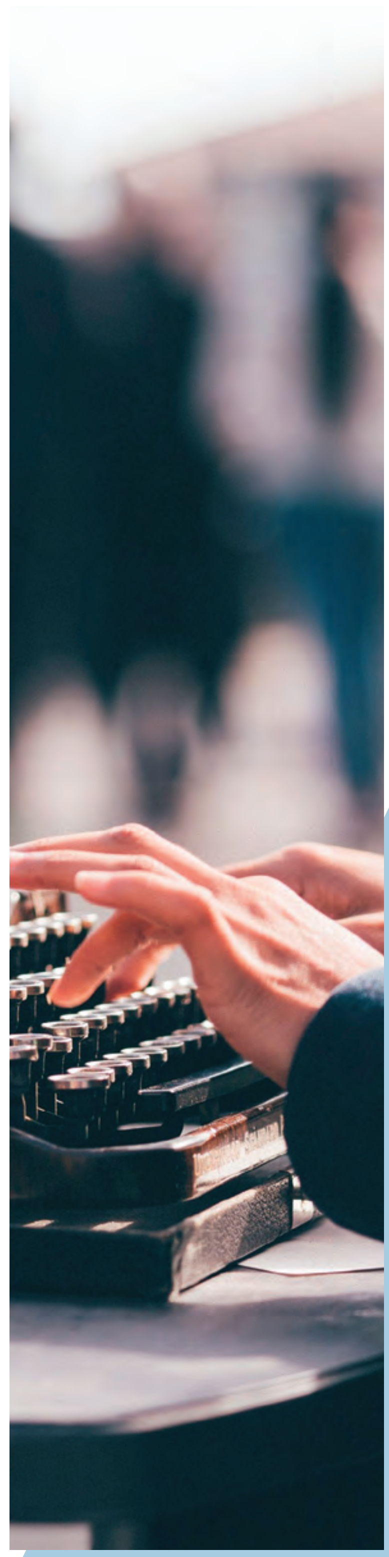
The pandemic is continuing to be a painful presence within our society; as we edge towards the path out, we lament on the things lost along the way. As students, this academic year has been a shadow of what it usually is – wards are empty, libraries are quiet for the wrong reasons and TBLs were restricted to a 1.5m distance.

Amongst the gloom, Nicholas Pavic, one of MedRevue's co-directors (alongside the talented Gowri Manesh), spoke of this year's MedRevue representing a pure, wholesome moment. While many doors had been closed, Medically Blonde was being seen by us as a source of happiness during a much-needed time. At first, I must admit that this felt a bit cheesy, but seeing the final product and what it meant to our community, I couldn't have been more wrong.

Watching the project grow from an idea on page, to a passion held by some of the most talented and charismatic people I've ever had the pleasure of working with; the play gave us an outlet of expression in a world feeling otherwise oppressed.

At points in the year we faced obstacles, but through the tireless effort of our producers, behind-the-scenes team and volunteers, we were able to bring joy into the hearts of many.

In a year faced with cancellations, Medically Blonde was able to stand as a testament to human endeavour and a love of expression. I would like to take a moment to thank everyone involved in the play, both in the making process and experiencing the event. Everything about it was amazing, I hope you all enjoyed it too.



VINTAGE WORDS - THOM MILKOVIC

MedRevue 2020: Medically Blonde

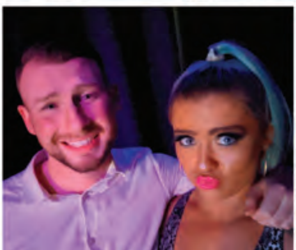
"You made a med revue during Covid-19, what, like it's hard?... Well... let's just say that our journey as directors followed a similar path to Elle's: Naive Optimism, followed by self-doubt and uncertainty. In fact, this med revue was almost cancelled 7 times, and it would have been if it was not for our only saviour: Zoom Video Communications. Auditions? Zoom. Rehearsals? Zoom. Hotel? Trivago. In all seriousness, we're so grateful to have been a part of such an amazing, loving, caring MedRevue family this year, and we hope that all those who came, really enjoyed our show!!"

- Co directors Nicholas and Gowri

"I signed up to Med Revue as it sounded like a lot of fun! I signed up for chorus as I wanted to be involved, but I'm no singer - I thought the other voices in chorus could drown out my screeching. I have made so many friends during rehear-sal and I had the best time doing it. I'm so impressed by how talented my new friends are. Watch out in 2021, Karen got a taste of fame and she liked it " - *Shannon*

"Being new to Flinders this year, I found MedRevue both a rewarding outlet for my musical passions and an amazing way to meet medical students, especially in other year-le-vels. It provided a unique creative outlet compared to the very structured nature of medicine, as well as being a welcome distraction, breaking up full weeks of study. It was very rewar-ding with a such a vast range of people - seeing the show come together after months of hard work was immensely satisfying. It has given me a great support network, with students in older year levels already being so kind in giving study tips. I did not anticipate meeting so many friendly, passionate, like-minded people. I am looking forward to MedRevue for years to come!"

– *Christine Mausolf*



MedRevue 2020: Medically Blonde

"Through the MedRevue Looking Glass. After being part of MedRevue every year, I can honestly say it has been an oasis in the occasionally gruelling environment of medical school. MedRevue has been a place where I can pursue my musical and theatre interest, surrounded by the most amazing and talented group of peers. It is a place of encouragement and enjoyment without any concern of judgement by others, where friend-ships are forged that last the entirety of medical school and beyond. I simply cannot imagine not having done MedRevue because it not only brings joy and laughter to others, but also has been a crucial part of finding my own happiness throu-ghout the last four years." - Lawson MD4 (2020)

"MedRevue continues to be the highlight (and Mahara fodder) of the year for MDs and clin scis alike. Even after being part of it for 3 years, it still never fails to astound me at the amount of talent around us that we would not normally be privy to. MedRevue is where you see the true and unfiltered characters of medical students burst to the forefront. There's nothing like creating a musical production from scra-tch, by students for students, that brings people together and builds these lifelong connections. Medicine is full of work and hardship, but having a group of people who you can joke (and sing) about it with is one of the best things that a medical student could ask for." – *Wendy*

Special thanks to Paul Thalaivasal for photos

Wright Evans MedBall 2020 - In to The Jungle

Hope you enjoyed it

-Elise & Simon

AMSA National Convention 2021 Comes to Adelaide

Australian Medical Students' Association (AMSA) National Convention is known to be the largest student-run conference in the world. The Convention brings together over 800 medical students from across Australia and New Zealand. Over one week, the delegates can explore academic programs with inspiring speakers, workshops and field trips during the day. In the evening, there is an opportunity for delegates to enjoy social programs with several themes to build connections with peers from across the country. In 2021 it's coming to Adelaide and yours truly is apart of an Adelaide and Flinders University team to bring this to life.

My passion for AMSA National Convention starts in 2018 when I attended my first Convention held in Perth. It came to me as a huge shock that full-time medical students delivered a week-long Conference which gave me unforgettable memories and an opportunity to interact with inspiring speakers whom I would have never encountered. My favourite memory during the Perth Convention was at the opening ceremony seeing over 1000 medical students in their university jersey in one area, being thrilled to meet other like-minded passionate medical students from other universities and doing the Convention dance together. This experience became my first step to be involved in AMSA, which led me to become a junior AMSA Representative of FMSS last year then a senior AMSA Representative this year and the secretary of the Adelaide Convention team. Becoming the secretary was the best decision I made last year especially as it is a once in a lifetime opportunity. The role helped me to upskill in so many different ways especially in communication and negotiation skills. Through this journey, I was able to establish treasured friendships with whom I can laugh with.

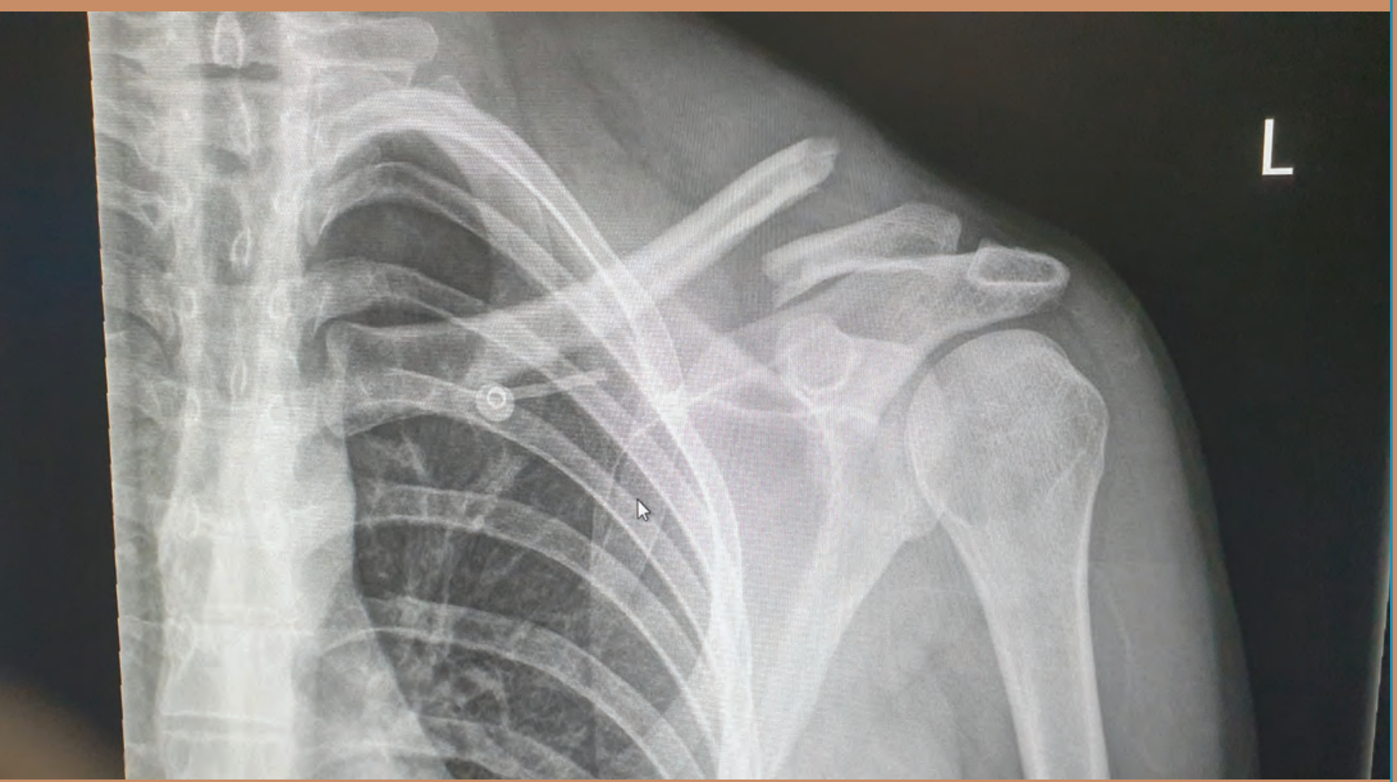
Sai Laxmy Chandramohan, a Creative officer of the Convention team, summarises her journey in three words: joy, family and dream-chasers. She especially has enjoyed retreat with the whole Executive team, numerous brainstorming and upskilling sessions, monthly catchups with the team, filming promotional videos and media launch. Ariella Joyce-Tubb, an Academic Convenor, describes that she has strengthened old friendships, made new ones and has expanded her networks across several other universities. She has mentioned that it requires a lot of problem-solving and to be constantly fine-tuning communication skills. However, it has been an exceptionally valuable experience.

- JOIN FMSS & AMSS COMMIT TEE WHO WILL BE PLANNED THECONVENTION

It has not been easy to plan the world's biggest student-run conference during a pandemic. We had to alter our timeline and budget several times as the restrictions changed repetitively. We had to develop multiple back-up plans to be prepared for all the possible scenarios in the future to deliver the best quality Convention for students who make time to attend the conference. Despite all these unforeseen circumstances, I have been extremely enjoying my journey in the Convention team, as this is so much more than just working on an event. It is becoming part of a family. We, as the Convention team, look forward to welcoming all Flinders medical students to the conference full of inspiring and high-quality programs that will be embedded in each student's memory forever.

Written by Jayda Jang

RIP Harry's Collarbone



Thank you to everyone that contributed to this issue of Placebo. Although this year has been unique and presented many challenges, we have still been able to create a magazine which we can be proud of. Placebo 2020 could not have happened without all the Writers, Editors, Designers, Artists, and the Ramy Robin himself.

- Marketing team

Onwards and Upwards from here folks.

FLINDERS MEDICAL STUDENTS' SOCIETY