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PLACEBO

GLOBAL HEALTH

OFFICIAL MAGAZINE OF THE FLINDERS MEDICAL STUDENTS' SOCIETY ADELAIDE, S.A.

Estelle Blair-Holt
Avant member

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OTHER FEATURES

Cover: Goa, Panjem: Bom Jesus Basilica: Traditional, colonial, severe, austere; brimming with life.

EDITORIAL

It's easy to think that Planet Earth isn't such a great place to be at the moment. The media bombards us with stories charged with despair and, let's face it, our leaders aren't exactly an inspiring bunch. I wonder if the astronauts aboard the International Space Station see more polluted grey, war-ravaged black, and famished yellow than the blues and greens of perpetually outdated atlases. Our world is sick – there are no false-positives about it. She's febrile, covered from pole-to-diaphoretic pole in suppurative lesions, and suffering the effects of dysbiosis. Fortunately, her illness, though serious, is not terminal. Hope has proven to be a very effective therapy and she's colonised with plenty of decent bipedal organisms who can transpose it.

How exactly does one of these organisms make a difference? Can it extend influential processes into its immediate environment or should it migrate to a remote, often hostile location? I've just about exhausted the IMD metaphor. In short, I firmly believe that we are all capable of making the world a better place, no matter how or where we choose to carry out our wonderful vocation. Desmond Tutu said, 'Do a little bit of good where you are; it's those little bits put together that overwhelm the world'. Whether you become a general practitioner in Adelaide (or Darwin) or a cardiothoracic surgeon in a generator-juiced, middle-of-nowhere shack, your efforts will make a difference every day.

I was drawn to Placebo because of my Equator-crossing, wanderlust-curing, British Army upbringing. I was born in Rinteln, a small town in Northern Germany not far from the Pied Piper's Hameln. My family was posted to Northern Ireland where, because of the threat from the IRA, we lived behind a barbed wire fence within an Army camp. My only memories from these two years consist of monotonous circuits of the soggy Base punctuated by bribes of chocolate buttons from the NAAFI! From there, we were sent to another damp location, this one markedly warmer being just 5º North of the Equator. Brunei, with its thick jungle, snakes, macaques, monsoonal downpours, and empty beaches lapped by the South China Sea, made me different. From an early age, I appreciated and respected diversity. Our final years in the British Army were spent back in Germany in Paderborn. We emigrated to Australia in 2003, only to move to England 18 months later. Finally, we returned to Australia in 2007, becoming citizens in 2009. From the Arctic Circle to the peaks of the Remarkables and many places in between, I am incredibly lucky to have seen so much of Planet Earth. The world isn't as scary as it so often seems and I know that I can give back to my global family.

I hope you too are inspired by this magnificent Global Health issue of Placebo Magazine.

ALICE DALRYMPLE, EDITOR

I'm from Perth. I know I go on about it, but it has really shaped who I am. Perth is the most isolated capital city in the world, so I feel like I've grown up pretty far away from civilisation of any description. I imagine it was the same for those of you who grew up in Adelaide, because while it is slightly closer to Melbourne, which I am told by my hipster friends is the centre of the world, it is still very isolated. In the words of the most famous Adelaidians, the Hilltop Hoods, 'We're nowhere near nowhere you would know of…I don't tell 'em where I'm from, I tell 'em where I'm close to.' This really hit home for me when I was travelling abroad, I told some Americans I was Australian and was immediately asked if I was from Sydney. When I tried to explain where Perth was I was met with blank stares and then they asked if I had a pet Kangaroo and if I wanted a pint of Fosters. I think it can be hard for an Australian abroad to know what their place in the world is. We are certainly well liked, not quite as much as the Canadians are (except the gingers), but someone will always have a beer with an Aussie. I suppose we are pigeon-holed a bit and I even put on a bit of an accent and grew a bushman's beard just to play the part. We can use this stereotype, however, to help find our way in the world, even as a part of the medical profession.

As medical students, we are now part of a global community of medical professionals which means we need to start finding our place in the world as doctors rather than just as global citizens. We need to think about what our responsibilities are as Australian doctors. We are isolated; isolation can bring perspective. We are well liked; affection can bring influence. We're good for a chat and a beer; we're great collaborators. I think Australian doctors have an important role to play in global health. It's not easy to find your place in the world. Maybe you end up working in the developing world, with Mercy Ships, in a refugee camp, in rural Australia, or even in the city, freeing up someone else to go and work in these far flung places. Maybe this issue might give you some hints about where your place is!

JAMES COHEN, PUBLICATIONS OFFICER

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The Placebo team of 2016 would like to acknowledge the Kaurna people, the traditional custodians of the land on which this publication is produced. We pay respect to Elders both past and present and recognise their continuing connection with their land and country.

We would also like to thank the following contributors for their enthusiasm and patience – this issue has been a long time coming:

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Finally, we would like to wish our departing Director of Publications, Matt Hayes all the best for the future. Thank you for introducing us to Placebo Magazine – it has already enriched our time at medical school. We look forward to hearing about your adventures!

CONTRIBUTE TO THE NEXT ISSUE OF PLACEBO!

If you have ideas for the upcoming issue on "The Future", email us at **publications@fmss.org.au**, *or just have a chat with Alice or James. We'd love to feature your work!*

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35 Parkade, Ottawa International Airport 1, Alistair Williamson

FROM THE PRESIDENT

Hello and welcome, everyone, to another fantastic year, where 2016 is well and truly underway now. In the blink of an eye, several months have gone by already. Things have been full steam ahead for FMSS since the beginning of the year.

By now, the first years will have settled into the daily routines of PBL and lectures. I hope the efforts of the FMSS committee have made the transition into medical school as smooth as possible. The year began with fantastic O-week events, with most of the events being lead by Shima Zahrooni. This was closely followed up by a hugely successful med camp, organised by the wonderful Maverick Daniel and Kyra Barnes. I'd like to take the opportunity to thank them and everyone who took the time to help out. Without their efforts and the collective efforts of the committee, none of it would have been possible.

The academic profile for FMSS has been another area of great success! Peer teaching has been a huge success again. Lead by Alexandra Durman, peer teaching for the first year students has been very well subscribed. It's fantastic to see such a great and ongoing teaching culture in our medical school. FMSS, through the efforts of our fourth year representatives, has also initiated peer teaching for third year students. Shefta Huda, Catherine Choi, and Alex Vidovic have set up a solid peer teaching schedule covering key topics from each of the five disciplines. They have also been advocating strongly for more teaching to be implemented for fourth year students. I'd again like to thank the collective efforts of the FMSS academic portfolio and all of the peer tutors who have volunteered their time to help their peers in their quest for knowledge acquisition.

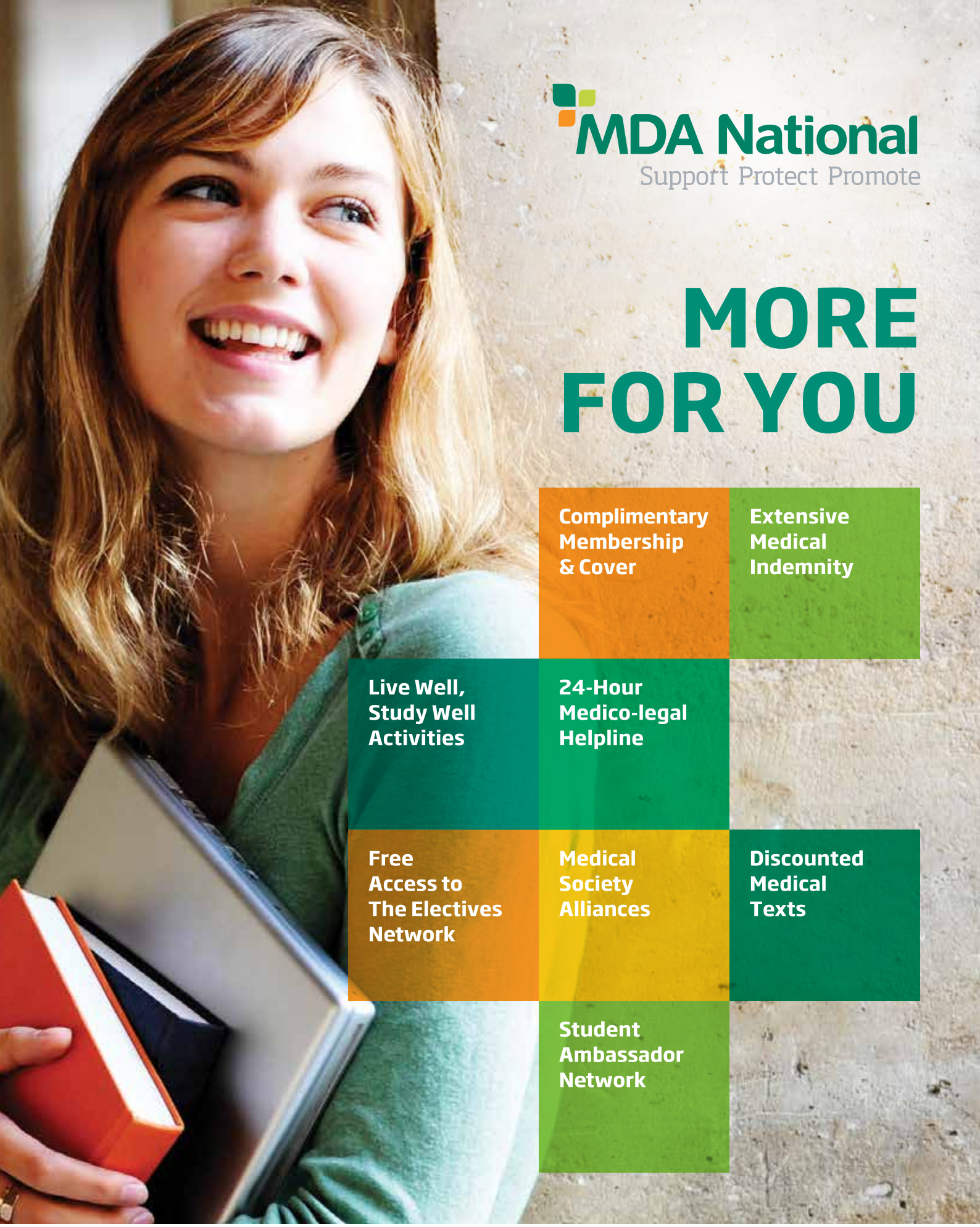
One of the key areas of advocacy that FMSS will be tackling this year is the current situation surrounding internships. There has been much talk amongst students of all years, but in particular the third and fourth year students that will be graduating soon. It has been an ongoing area of discussion for many committees, boards, councils, and societies across South Australia and Australia. Whilst it often feels like not much is being done, I'd like to assure students that FMSS is working hard at this issue. This year AMSA has developed a national advocacy team, on which a representative from South Australia sits. FMSS has been working closely with this newly formed advocacy team to tackle this primary issue of internships. FMSS is also maintaining advocacy on several different platforms; we have representatives that attend meetings with the Australian Medical Association (AMA) (SA) and the South Australian Medical Education and Training (SA MET) committee and we take any opportunity to raise this issue.

With the primary theme of this Placebo being Global Health, there is no doubt that the AMSA Global Health Conference (GHC) requires mentioning! This year the annual conference will be held in Newcastle, with some amazing speakers lined up. From a Nobel Prize winner to a Professor of Civil Engineering from the United States, GHC in 2016 I'm sure will prove to be a valuable experience. Moreover, it should also be mentioned that GHC will be held in Adelaide in 2017! This is such an amazing opportunity for medical students across SA to get involved in. I am excited and keen to see what directions the Adelaide team will take in their organisation of GHC. I wish them all the best for next year!

So much has happened already this year, with many more events to come! This year also marks the return of Med Revue for FMSS! I hope everyone is excited for what's to come! Of course it must be highlighted that a lot of the events and programs FMSS organises for everyone could not be possible without the help of our sponsors. Their help has been paramount for us to organise such high quality events for the cohort.

So, what a year it's been so far! With so many amazing things already achieved by the FMSS team, I am very excited to see what's to come for the rest of the year. No doubt all of the work we do couldn't be possible without the efforts of everyone in the committee! Special mention goes out to the executive committee, as they've been at weekly meetings and working so hard behind the scenes to help create successful and amazing events! Thanks to everyone in the committee, because you all do such great work!

STEVEN TRAN, GEMP 4



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KRIS WILCKENS, GEMP 1

Home

In the second half of 2015 I went backpacking in Europe for 4 months. My bag was heavy, filled with clothes for all seasons because I had not yet decided where I would visit. My journey through Europe was one of comfort. While I scrimped and saved every Euro I had, buying the cheapest food and staying at the cheapest hostels, I was fed and warm. At the same time, thousands of others with different goals in mind began their journey across Europe under very different circumstances.

I left London by bus in August. I was concerned that I wouldn't be allowed to catch my ferry from Dover because of the recent spike in migrants attempting the crossing to England disrupting the channel tunnel and ferries. I had heard about the humanitarian crisis in Europe during my time in the UK but had little concept of the scale. The UK, then a member of the European Union (EU), had to take its share of refugees, however, it was reluctant to do so. Vast numbers of people were left in limbo, stranded in despicable conditions on the other side of the English Channel in Calais. The shanty towns were just one outbreak of Cholera or some other disease away from tragedy. Some countries, like Germany, did open their doors with offers of safety and work.

For the majority of Syrian refugees, the journey begins on foot as they cross the snow-capped mountains into Turkey. Here they buy their way onto a boat to a Greek island. In 2016, close to 160,000 refugees arrived by sea, the majority to the island of Lesbos. The journey is dangerous, the boats unseaworthy. Many are sold fake life preservers and thousands don't make it. The refugees are then ferried from the Greek Islands to Athens where they arrange passage through the many borders, spending what little they have on the chance of safety. They cross into Macedonia, Serbia, Hungary, Austria, and, the end goal for many, Germany. Much of the journey is completed on foot in freezing temperatures and damp living conditions that lead to trench foot and respiratory tract infections. With each passing day, the new arrivals place an even greater strain on the public health systems of the countries that take them in. Hospitals are overwhelmed with cases of resistant bacteria and infectious diseases rarely seen in the developed world.

As a tourist, I could feel the tension. Each individual I spoke to had different concerns. Many felt betrayed by their government as hundreds of arrivals strained their communities. Similar arguments were made to those that I had heard before in Australia: Where will they work? Will they integrate? When will we have given enough? For these people, I had no answers. I smiled and said, "I guess your government is just doing what it can. It's a challenging time." This was often met with a change of conversation as they could see I did not share their disdain for migrants. There were also outpourings of compassion and support. I

heard stories of crowds of people standing at the Berlin Hauptbahnhof with signs bearing messages of support and welcome. These crowds had dispersed when I arrived in Berlin months later. I hoped that the goodwill had not run out. What did remain were families huddled together with only jackets and sleeping bags on them and small shanty towns made of cardboard and styrofoam, architectural marvels yielding little protection from the rain.

Halfway though my trip the mood shifted again. Trains were stopped from crossing borders and the freedom of travel that the Schengen Agreement afforded was abandoned. The usually empty border checkpoints became centres of intense scrutiny. I had no trouble with my pick of British or Australian passport but I did wonder about the people living in the tents a few kilometres back from the border, or those walking along the tracks. They must have had a worse time as the tiny ray of light that was German sanctuary was snuffed out by the closure of the Croatian, Serbian, Hungarian, and, eventually, Austrian borders. How were these people meant to get from where they were fleeing to where they were wanted, or indeed entitled to be as refugees, if every border blocked their passage? They couldn't just book a seat on a bus or a plane like I could. How could the leaders of Europe, excluding Chancellor Merkel, be so short-sighted? I believe it was fear. Fear that perhaps the refugees might like Hungary, or Serbia, or whichever country they crossed into so much that they would stay and become a burden. It makes sense; if you love your country, surely you believe that others might love it too? Many Australians must feel this way.

It is a cliché that history will repeat itself. Indeed, with a history as expansive and varied as that of Europe how can it not? I was in Amsterdam when it struck me the most. I had queued early, wrapped up in jackets and scarfs against the cold, to beat the rush for a visit to the Anne Frank house, a must-see if you manage to navigate past the windows and the coffee shops. The story is well known enough. Anne and her family, along with a few others, lived in a hidden section of the house above Otto Frank's jam factory to escape detection by the Nazis. Otto had previously lived in Germany but, as he felt the tide of Nazism rise, relocated with his family to Amsterdam in the safer Westernmost nations of Europe. The Netherlands were not safe for long as Germany invaded in May 1940. During this time, Otto tried to obtain visas for his family to the United States or Cuba, successfully securing a single visa for himself to the latter. When Nazi Germany and Fascist Italy declared war on the US at the end of 1941, his visa was cancelled and all hope of escape from Europe was lost. Then as now, countries were reluctant to take in so many migrants and, with nowhere to go, there was no escape from the genocide that followed.

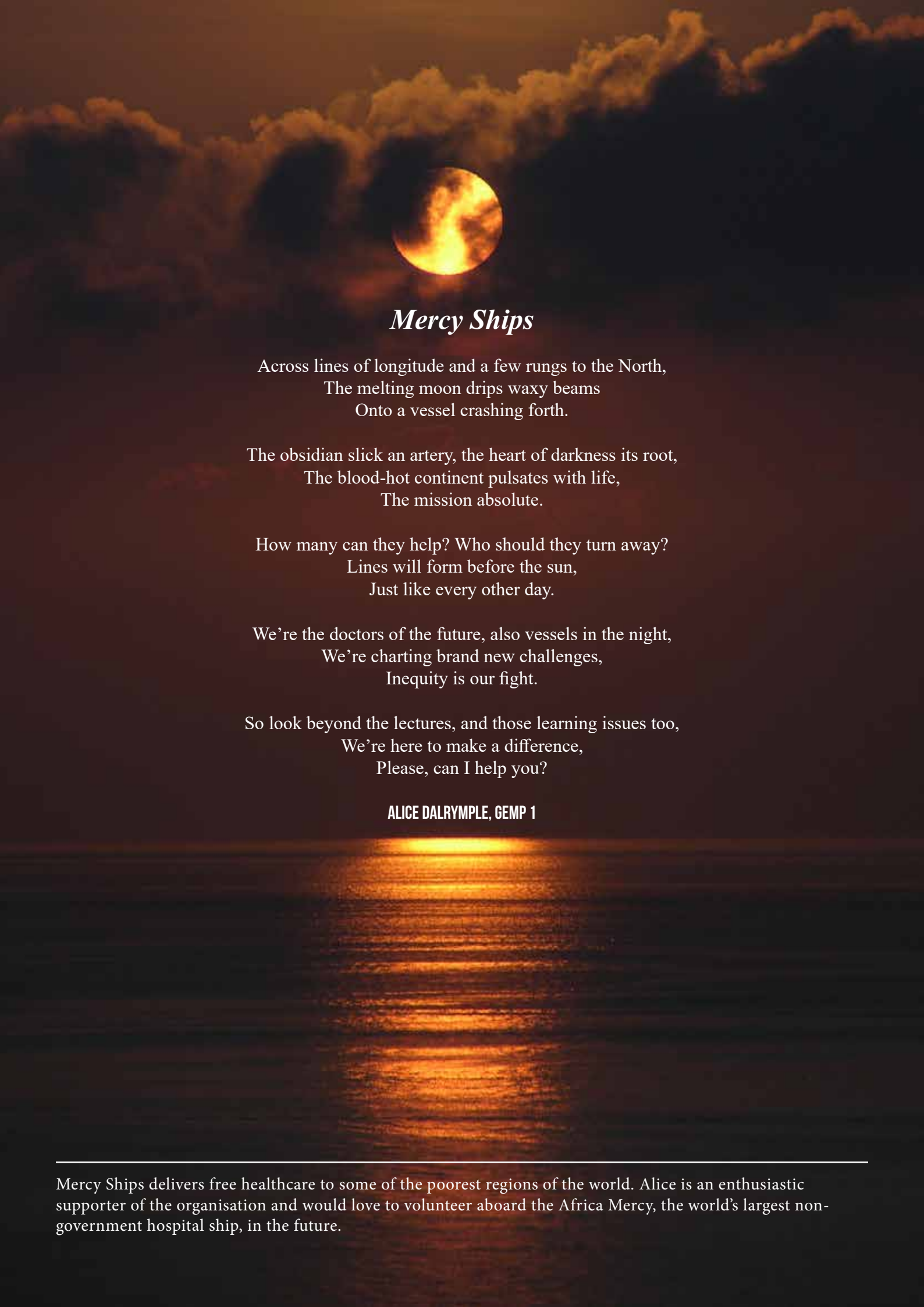
Perhaps it is guilt that now spurs so much charity from the German people. This guilt is palpable. The German youth, who can hardly be blamed for the atrocities of the Holocaust, to me seemed burdened by the mistakes of the past. Will our children experience this same feeling, knowing that we stood back and allowed thousands of people to suffer? There is a tendency to dehumanise these people. Leaders like David Cameron describe the numbers of people seeking refuge as a "swarm" or a "bunch of migrants". The current climate in the UK in the wake of Brexit is one of mistrust of migrants and of Europe. Even Australian leaders refer to refugees as "boat people", an attitude that makes it easy for much of the population to forget that these people are just people. People with lives torn asunder. People with fears and dreams. Mothers. Fathers. Children. I've heard the arguments that say: "What if they aren't genuine refugees? They could be economic migrants", or, "What if they are criminals or terrorists?" I don't seek to take away these individuals' right to fear, just like the leaders of Europe. These thoughts crossed my mind too but by the end of my trip, after seeing the refugees, I wasn't afraid. I didn't really care who they were because, just like me, they were travellers ready to go home.

JAMES COHEN, GEMP 1

By KEITH STOTT and ALICE DALRYMPLE

THE HEART OF THE SEA

Join Placebo aboard the Africa Mercy, an emblem of Global Health navigating inequitable waters.



Mercy Ships

Across lines of longitude and a few rungs to the North,
The melting moon drips waxy beams
Onto a vessel crashing forth.

The obsidian slick an artery, the heart of darkness its root,
The blood-hot continent pulsates with life,
The mission absolute.

How many can they help? Who should they turn away?
Lines will form before the sun,
Just like every other day.

We're the doctors of the future, also vessels in the night,
We're charting brand new challenges,
Inequity is our fight.

So look beyond the lectures, and those learning issues too,
We're here to make a difference,
Please, can I help you?

ALICE DALRYMPLE, GEMP 1

Mercy Ships delivers free healthcare to some of the poorest regions of the world. Alice is an enthusiastic supporter of the organisation and would love to volunteer aboard the Africa Mercy, the world's largest non-government hospital ship, in the future.

Ship's Blog - 24 June 2013

The Final Chapter…

After nearly 5 weeks, the time has come to think of departing. I will soon be winging my way to the comforts of home and family. It has been a fascinating journey and there is much I shall miss about this ship and her crew. Amongst said crew are many unsung heroes that I have not mentioned – administrators, galley and housekeeping staff, chaplains, technical support teams, teachers, and many others all play their part in keeping this extraordinary enterprise going. To spend time again on a working ship has been a rewarding experience. To spend time on the Africa Mercy has been a privilege. At the end of my short journey, I am mindful of the fact that it is far from the end of hers or theirs.

A few more weeks in Las Palmas and once again transition will be the order of the day. She will slowly fill until she has more than double the current compliment and the emphasis will change as the medical role of the vessel becomes predominant. Hundreds of men and women with gifted hands and blessed hearts will take up their stations and prepare themselves for the best part of a year with the poor and forgotten of the world. As far as I know, this will be the first time that she carries out her mission South of the Equator at Pointe-Noire in the Republic of Congo.

Congo was first made famous by the rigorous adventures of Stanley and Livingston. It is the land of Pygmies, mythical beasts, plagues, and cannibals. Joseph Conrad called it the 'heart of darkness' and it has long suffered ethnic violence. Its eponymous river is the deepest in the world and Africa's most powerful. No one really knows what to expect. There will of course be the usual logistical difficulties: the rainy season (Congo can have up to 80 inches per year); concerns about potable water; and arrangements for fuel (8 tonnes per day). An additional problem will be the fact that there are 62 spoken languages within the country.

After the shipyard, she will spend 10 days in Tenerife for final preparations. She will be loaded with drugs, medical equipment, fuel, oil, water, food and drink, spares for engines and generators, electronics spares, printer paper, toilet paper, tracing paper, pens, pencils, school books, and so on until she is entirely self-contained – a floating city complete with Hospital, Hotel, Fire Station, Garbage Disposal, Police Station, School – the only thing missing is the Pub. When she sails she will be low in the water, close to her marks.

She will sail South with the opportunity of passing through the legendary position, 000° 00.0 N/S 000° 00.0 E/W – easier to do now with Satellite Navigation than when I did it last with Sun and Star Sights and Dead Reckoning. At Pointe-Noire, what was packed only a matter of weeks ago will be unpacked so that the off-ship teams can set up clinics and care centres – the 27 Land Rovers, their drivers, and the maintenance crew will be kept busy for 10 months. When ready, she will throw open her doors and invite the sick, the lame, the desperate, the unloved, and the dying to come and be cared for.

What is it that inspires over 400 people from over 30 nations and such diverse backgrounds to come here? The simple answer is faith but there are as many reasons to be here as there are people on board. Mercy Ships is a non-denominational Christian charity, however, you do not have to be a Christian to serve. Faith inspires people to come and is the glue that binds everything together. Need gives clear purpose to all those who sail. Mercy Ships is a uniquely focused organisation.

Don't make the mistake of thinking that this is a happy clappy band of Christian do-gooders. These are tough people who work in extreme conditions. Any person on this ship would be willing to put their backs under a Land Rover up to its axles in mud just to lend a hand. There are time-served men from the navies of Great Britain, New Zealand, and the United States. There are Dutch Officers who cut their teeth on small coasters during freezing winters in the North Sea and the Baltic. There are firemen and policemen and engineers who have spent their lives on ships or building coal fired power stations in the forgotten parts of Australia. There are surgeons, anaesthetists, dentists, nurses, and palliative care staff. And then there are the electricians – one Geordie and two Canadians – the centre of mirth and mayhem.

It is a unique environment, with little tolerance of politics or prejudice. It is refreshingly low on ego – it doesn't matter who you are or what you do here, the important thing is that you are here and that you are contributing. It is a positive, supportive, and caring environment based on respect for the individual. Above all else it is a place of action, a place of getting things done – these people are missionaries whose focus is on mission. This is not a ship crewed by hundreds, it is a ship crewed by thousands. Across the world, speakers, supporters, and campaigners spend their time promoting what is effectively a little-known charity. Many more donate money, medicine, nuts and bolts, school books, coffee, tinted safety glasses – the astounding generosity is limitless and yet we all share one aim, the compassionate treatment of those in distress, the very definition of 'mercy'.

So long may she sail and long may the cry be heard, "the Mercy Ship is coming". For as long as that cry is heard, prayers are being answered and an example set by a man who trod the shores of the Sea of Galilee 2000 years ago is being maintained, bringing hope and healing to the world's forgotten poor. I shall miss this place.

KEITH STOTT

Keith is married to Alice's father's first cousin once removed – try saying that 5 times faster! He served as an Officer in the Merchant Navy (United Kingdom) from 1975 to 1982 and lent his carpentry skills to the Africa Mercy in May/June 2013. His enthralling blog can be viewed at: ***https://keithjstott.wordpress.com***

The Surgeon and the Ship

"Tell the surgeon to make haste..." -Horatio Nelson.

Alice Dalrymple sat down with Bega-based surgeon, A/Prof AJ Collins to discuss his experiences aboard the Africa Mercy.

How did you hear about Mercy Ships and why did you get involved?

They put up a stand at a RACS – so the Royal Australasian College of Surgeons – Scientific Meeting. I'd been to Africa on two occasions before but they weren't very fruitful because of the logistics of arranging work and because of the limited resources. I just got the impression that Mercy Ships was well-organised and so I gave them my details. I didn't hear from them for about a year and then one day they rang me up because they were looking for a thyroid surgeon. 2007 was the first year I went and I've been every year since apart from when we couldn't run the thyroid clinic in Sierra Leone.

What are some of the major challenges surrounding the provision of healthcare aboard the Africa Mercy?

I might answer it the other way round and say that's one of the great strengths of Mercy Ships – it's highly resourced and highly organised, so opposite to the situation in most places in Africa. Their equipment, budgets, and resources match those of most middle level hospitals in Australia so they're able to carry out a huge number of complex operative procedures. Are there some challenges? Well yes, you have to fly to other countries and work in unfamiliar environments but you also get to work with people who speak your language. Sure, the people from that country speak other languages but every ward has three interpreters 24/7. Adjusting to a new time zone can be challenging. In terms of your normal body clock, you're finishing work at about 1am. I'm prepared for that now – in my first week, I just tend to collapse in bed 30 minutes after work finishes.

Dr Damien Brown, author of Band-Aid for a Broken Leg, volunteered with Médecins Sans Frontières (MSF) in Angola, Mozambique, and South Sudan. He struggled to readjust to 'the very epitome of modern medicine' upon his return to Australia. Does it take you long to settle back into our accessible, affordable healthcare system?

I think MSF has a different feel for the work they do – they operate in crisis zones and that's very specifically not what Mercy Ships does. We deal with chronic, degenerative diseases that have not been treated because the country just doesn't have the resources. There is a very strange adjustment period when I come back to Australia. I see people with 10 mm thyroid tumours and sometimes feel like telling them to come back in 5 years, which would be completely unacceptable. If you put their disease on the same spectrum as the patients on the Africa Mercy, they're only at the very beginning. You do get used to practicing in different places. Even though the severity of the condition differs with location, its effect on the person is fundamentally the same – so Mercy Ships treats the same diseases, just 30 years later than when they would be treated here, which obviously makes an amazing difference to the way they present.

Tell us about some of your most rewarding moments aboard the Africa Mercy.

The best moments are the human ones, when you see the happiness in a person's face and smile because you've reversed or completely taken away the problem excluding them from normal life. I've looked after a few women with thyroid tumours that were so enormous that their families called them witches or cannibals and kicked them out of their homes. For them, treatment is an opportunity to re-enter the lives that they've been cut off from and they have tears of joy about it. Just in February, a young woman told us that her brother and sister had stopped their children from playing with her children because of her large thyroid tumour and that everything was going to be different now that we'd taken her growth away. So they're the great moments really – the happiness and gratefulness someone has in that situation. It's the smile that tells that story, that means all of those things. It was worth coming just for that one person.

Is that what keeps you going back?

It probably is that sort of thing – and I like the work, the nature of it and how it's carried out. I sometimes have weak moments when I don't know if I can be bothered going – it's too much trouble, I have to take a month off work, it costs me lots of money – but then I usually sit myself down and think about the reasons that I want to do it and of course I do end up going. Again, it's so highly organised and efficient that it feels like a very worthwhile way to spend your time. It's an environment that's easy to live and work in, especially coming from Australia. You arrive on the Africa Mercy and it's like checking into a hotel. They're also very security conscious, so unless you go out at night after curfew or visit places they tell you to stay away from, it's extremely safe. Your life is generally not at risk – it certainly can be if you go to some of the MSF places in Iraq and Afghanistan.

What do you find confronting?

That's a hard one to answer. Turning people away is a very difficult, emotional thing to do – we won't risk life above a certain level. I've been to Africa 15 times in my life and so don't find the abject poverty at all confronting. On the other hand, Africa is a place of great natural resources and you do come across people who are staggeringly wealthy because they've got their finger on the pulse of the oil industry or the ore industry or because they mine diamonds. We talk about the growing gap between the rich and the poor in Australia but it's really no comparison – the gap in Africa is phenomenal. There's such terrible inequity in the distribution of wealth. Because Mercy Ships has Western doctors, every now and then a well-to-do person will turn up expecting help – we turn them away because they have the resources to fix their problems.

How can future doctors promote and support global health?

Be interested, be passionate, and find an area that interests you. Learn lots about it, get involved, and talk to people in the area. If you're passionate about something, you'll find a way to progress it. Sometimes you may need to alter the course of your training. Undertaking a medical elective in Africa is a well-worn path but it changed the course of my life and I knew that I would go back. Mercy Ships likes getting people in early because it gives them the passion and the drive to work for the cause.

ALICE DALRYMPLE, GEMP 1

The Girl at the Airport

I sat beside a sobbing girl in the airport that day. It struck me as insane that not a single glance was spared her way let alone words of comfort; as if the tides of weeping girls and women that had flooded these terminals before her had washed away all trace of the world's empathy, kindness, and human compassion. She was a human stain on the linoleum floor, soon to be lost amid the hundreds waiting to travel to foreign lands in search of work, prosperity, and anything better than the rough lot they had been dealt.

I asked this girl, who looked years younger than my 23-year-old self, what it was that caused her to weep so heartbrokenly. "I have a daughter", she said, "and there is no father."

These last words came out as a shameful whisper, a secret kept to protect a little being from the judgment of the world. A little being who, from today, would essentially be an orphan; her father absent from birth, her mother sending money back from Dubai, the capitalist heartland of the Middle East. "Everything will be alright", I was tempted to say. "Everything will work out", my Westernized mind rationalised. Reality is different but in the hours following this encounter, it was easy to forget the discomfort it caused, even as I boarded the plane filled with an exodus of labourers heading into the unknown.

There are a myriad of circumstances which could have forced this girl to leave her child behind, most likely related to her socio-economic situation at home. Despite the fact that tragedies and natural disasters form the bulk of the news that reaches us from the Third World, the turn of the century has brought rapid economic, technological, and cultural development to countries like Bangladesh. For example, the rapidly developing garments industry employs a workforce of which the vast majority are women; a very different picture to the labour force even a few decades ago. This socio-economic shift has also been reflected within other social demographics. More girls than ever before are attending and completing school and both maternal and child mortality are steadily decreasing. The adult literacy rate has jumped by approximately 20% in the last two decades, with the gender disparity in literacy rates also falling. The proportion of the population living below the poverty line has fallen from 48% at the start of the millennium to 31% in 2010.

And yet 31% of 161 million is a staggering number of human beings. A 2012 UNICEF report indicates that despite its recent economic successes, Bangladesh has one of the highest rates of malnutrition in the world. Of children under 5, 41% suffer moderate-to-severe stunting of growth due to malnutrition and many are born with a low birth weight. Every child born has already accumulated $200 of foreign debt before they take their first breath and half of the population is at risk of arsenic poisoning from local wells. Tuberculosis and malaria run rampant and contribute to a disease burden that is overwhelming the limited public health services. Broken roads and chaotic traffic claim 52 lives on average every day, as well as causing thousands of injuries. Poorly regulated and underdeveloped infrastructure contributes to the chaos and played a key role in the 2013 Rana Plaza factory collapse, which claimed 1,134 lives. Indeed, it is evident that the state of public health is undermined by a complex array of social, economic, logistical, and political variables.

The environment is another key player in determining public health. As the First World continues to debate the legitimacy of Climate Change, Bangladesh, the country deemed most susceptible to tropical cyclones, stands to lose 40% of its productive land with a sea level rise of merely 65 cm predicted to occur in our lifetimes. Projections demonstrate such an event will create millions of environmental refugees. Every year, the low-lying farmland of which most of the nation is composed is ripped apart by devastating monsoons, cyclones, and floods. Floods bring with them further health hazards, including the increased spread of disease, the loss of clean drinking water, the loss of sanitary disposal of human waste, and a general lack of safety for the men, women, and children who are turned out of their homes.

For women, there is an added layer of complexity. There have been improvements in women's conditions, particularly with the spread of microfinance options offered by banks, and the emergence of a vast garments industry with ties to most of the major brands we enjoy in the First World. The particular interplay of cultural, religious, and economic circumstances, however, means that girls are born into an uphill battle for safety, independence, and the pursuit of happiness. Public safety for women is a major struggle to which any visitor to the country can attest. The government has undertaken several initiatives to manage this, including media campaigns against public harassment, or so-called 'eve-teasing'. Sexual harassment is commonplace – it would be difficult for a woman to go out in public without experiencing some form of it – and rape is notoriously underreported. Much of the country blatantly ignores the legal age of marriage, with two-thirds of girls getting married before the age of 18. Consequently, an alarming incidence of early childbearing has resulted in large numbers of young women suffering obstetric fistulae, which often carry a significant social stigma.

For the health workforce, catering to the needs of Bangladesh's 161 million is a mammoth task. The density of healthcare workers stands at an abysmal 7.7 per 10,000 population. This shortfall is mostly felt by the poor and the geographically isolated, the victims of a hugely inadequate health sector mired by corruption and greed. Examples of corruption in the health sector include reports of unnecessary surgeries, false diagnoses to enable expensive and unwarranted treatment, bribes taken in hospitals, and even spine-chilling allegations of early induction of labour with the intent of admitting premature newborns to the NICU for a few extra weeks.

These facts and statistics represent the life that the girl at the airport was likely born into. They provide some explanation as to what would motivate a teenager, not long out of childhood, to leave her even younger daughter behind and look for a better future elsewhere. Rapid globalization has inevitably tied my world to hers, not just as a person of Bangladeshi origin, but as an Australian shopping at Big W, or as a citizen of the world reading the news, or even as a future healthcare professional with an interest in public health. The truth is that neither of us had any control over the circumstances into which we were born. Had she enjoyed the same care and privileges I have enjoyed in my life, this young girl could be healthy, happy, and successful today. In the twenty-first century, with all of its technological prowess and social development, it is no longer acceptable that teenage girls suffer unnecessary complications of pregnancy or that children remain malnourished, when much of this could be avoided with education alone. NGOs have improved public health in Bangladesh and the astonishing advancements in the social determinants of health in the past few decades clearly indicate that eliminating socio-economic disparities is not an impossible task. I am hopeful that someday our children will meet under much better circumstances.

SHEFTA HUDA, GEMP 4

Terrorism and *Health*

Above: Tareq Kamleh featured in Daesh's recruitment video

When terrorism is mentioned in the media, it's usually accompanied by a death count or an assessment of territorial control. Reports focus on grisly acts of violence, victim tallies, and counter-terrorism strategies. There is an overwhelming focus on the military and security aspects of terrorism. What often isn't explored, however, is how organisations that carry out acts of international violence impact healthcare in the regions they operate. This article seeks to shed light on how healthcare has been affected by global terrorism. This effort will not be exhaustive or representative, but I hope that highlighting the consequences of violence can help us navigate personal practical decisions as future physicians.

Acts of terror and hospital burden

In November 2015, a slew of coordinated bombings and shootings in Paris killed 130 and injured many more. In the wake of these attacks, a sudden and immense influx of patients put severe strain on nearby hospitals. Confusion and panic ensued, with scattered information on the ground threatening to hamper the efforts of emergency crews.

About an hour after the first attacks, the government put a recently-passed emergency healthcare response plan into action. Large numbers of off-duty healthcare personnel were called into work, ambulances were deployed, and hospital beds were prepared to meet the influx of new patients. The state of emergency lasted well into the next day and involved seven hospitals.

Having a contingency plan probably saved many lives. Such plans are part of a movement towards disaster preparedness for mass casualty events. The attention to detail is considerable: for example, when officials realised that terrorist acts often occur in the afternoon in order to maximise coverage on the evening news, they made sure that hospital shift changes were set in the afternoon so that manpower is doubled during that time. The persistence of terrorist organisations, compounded by the difficulty of monitoring and pre-empting violent attacks, makes emergency manpower and protocol planning increasingly crucial and life-saving.

Healthcare provision

Aside from sowing violence overseas, many terrorist organisations also undermine civil infrastructure in the regions in which they operate. Self-proclaimed Islamic State (Daesh) and the Abu Sayyaf Group in Philippines both aim to establish territories governed by Islamic law. Daesh is skilful in social media management; it posted a hospital promotional video extolling a new Raqqa hospital, replete with refurbished units – even a women-only unit. An Australian doctor, Tareq Kamleh, is shown in the film saying that he travelled from home to join Daesh in order to use his medical skills "as part of my jihad for Islam". He even wrote a letter explaining his "educated decision" to join Daesh. Kamleh interned at the Royal Adelaide Hospital and even won the 'golden speculum' while there, so this cuts pretty close to home.

Governments are grappling with the fact that some of their citizens, many of them young and intelligent, spare no effort to travel to help Daesh. The group is able to solicit global healthcare talent to bolster its efforts, simultaneously draining its opponents of this talent. While it is a tiny minority that do leave their homes to help terrorist organisations, it is enough for governments to respond with targeted messaging of their own. For instance, the UK developed emotive videos with Syrian mothers warning other mothers on the dangers of bringing their families to Daesh-held territory.

In other cases, healthcare professionals are forcefully taken. In the Philippines, the Abu Sayyaf Group has kidnapped healthcare workers, possibly to treat the group's own members. In Syria, Daesh has reportedly executed surgeons for refusing to transfer to field hospitals to treat their fighters. This raises some ethical issues; as healthcare professionals, do we make a distinction as to who we treat? What if we were forced with threat of death to help terrorists?

Control and social services

Another aspect often overlooked is the health of the people living in controlled territories. Although its promotional material would never show it, the healthcare system in Syria and Iraq is embattled. Here is where writer Archit Baskaran identifies the "Islamic State Healthcare Paradox": In its effort to create new state machinery, the group first has to supplant existing infrastructure, then replace them with their own. This is where the groups often fail to deliver due to the lack of resources or coordination.

A WHO report on health in Syria and Iraq dated December 2015 stated the humanitarian situation continues to deteriorate after nearly five years of sustained conflict. 57% of public hospitals are either partially functioning or closed down, with shortages of staff, equipment, or damage to infrastructure. The report also details obstructions to the delivery of lifesaving medical supplies and outbreaks of pertussis, severe acute respiratory infection, and cholera. In 2013, Syria also saw the rise of measles and its first case of polio.

Extended conflict fuelled by violent organisations has taken a toll on civilian life and health. As future health professionals facing these dire situations, several questions can be asked, including whether we would want to work in such areas of great need and conflict.

Refugee crisis
The impact is also felt on foreign shores. More than five years of ongoing conflict has pushed more than 4 million refugees out of Syria, most toward Europe. World Vision Australia estimates more than half of these refugees are children. Affected countries have taken diverse approaches to the refugee influx. In March 2016, the French government began demolishing the refugee camps where many are stuck. In response, nonstate actors like Médecins Sans Frontières (MSF) sought approval and began constructing new camps.

The refugee crisis highlights the fact that terrorism creates downstream effects that spill over past conflict zones. Many students aspire toward a career in international humanitarian aid and look up to organisations like MSF, Red Cross, and Adventist Development and Relief Agency (ADRA). But it is hard to imagine working in conditions that MSF executive director Vickie Hawkins has called "some of the worst" seen in more than 20 years of humanitarian work. As future health professionals, where do we stand on issues like the refugee influx?

Above: Refugee camps in the flood-prone Grande-Synthe area, France.

(You can read an on-the-ground account of the refugee situation in Europe in James' article "Home" on page 8.)

The new face of warfare
Though the nature of war might not change, methods of warfare change with technology and ideology. Analysts have identified a worrying new trend in the method of war, seeing civilians and public health infrastructure become targets. This is in contrast with previous conflicts where such actions would be considered abhorrent. Especially in the Syrian conflict, healthcare facilities are seen as strategic assets that each actor in the conflict is loathe to surrender to its opponents; hence, healthcare facilities are often targeted, damaged, or destroyed.

A hospital in Aleppo was bombed as recently as 28 April 2016. The hospital's location was known to all parties involved in the conflict and was the area's only paediatric referral centre. WHO Director-General Margaret Chan issued a statement "expressing outrage at the attack" and noting that among those killed were "doctors, including one of the remaining paediatricians in the city, paramedics, and numerous patients." This paradigm shift in the 'rules' of war requires a concomitant shift in health professionals' minds - in future instances of war and conflict, the prime targets might very well be non-combatant medicos.

A culture of fear and mental health
Although the spectre of terrorism may seem far removed, many countries have seen their fair share of attacks. The Lindt cafe hostage situation happened right here in Australia. The constant threat of such attacks, compounded by sensationalist reporting, can create a culture of fear. A November 2015 news article revealed Australians "overwhelmingly fear a Paris-style terror attack on our shores."

In response to such threats, people may change travel plans, become more suspicious or paranoid, and suffer consequences for their mental health. During the September 11 attacks, emergency hotline operators took a barrage of calls from people trapped in the collapsing buildings. Confused and ignorant of the actual situation on the ground, operators continued to speak to and reassure callers. When the phones went silent, the operators had to deal with the enormity of having spoken to people in their last moments. In phone transcripts released, operators were heard telling callers: "Take care"; "Bless you"; "Hold on"; and, "Help is coming". Many operators left their jobs subsequently.

Above: Dr. Muhammad Wassim Maaz, the Medical Director of the Pediatric Hospital in Aleppo supported by Independent Doctors Association, was killed in the hospital bombing.

Amidst the rising culture of security and fear, physicians may see a rise in mental health issues arising from the threat of terrorism. On a broader scale, the burden on the healthcare system might increase and we might see shifts in demand for different types of care and training.

Our role in the future
This article has attempted to draw out how global terrorism today affects various aspects of health. Whether it's facing a new culture of fear, engaging in hospital emergency planning, or deciding on areas in greatest need of healthcare, we face many decisions as future physicians. It may well be that we never experience anything related to terrorism, or it may become our reality with a wrenching suddenness. Any number of related questions can be posed: How can health professionals improve emergency responses in the face of terror attacks? Should we help with overseas medical humanitarian efforts given the increasing risks? What are novel ways to improve global health in areas of conflict? It is my hope that being aware of these challenges will spur more efforts on our part and improve health outcomes.

ANDREW PHUA, GEMP 1

Vietnam in *Sight*

Dr Nong Van Ang is an ophthalmologist who has been working at Cu Giut District Hospital in Dak Nong province, Vietnam, for 6 years. Originally from Cao Bang province, he studied at Vietnam Military Medical University in Hanoi. In 2013, Dr Ang received a training course from The Fred Hollows Foundation (FHF) at Cho Ray Hospital, Ho Chi Minh City.

Matt Hayes (GEMP 2) and Adelyne Huynh (GEMP 3) recently caught up with Dr Ang to gain a better insight into the work that he is involved in, and the support that The Fred Hollows Foundation has provided in improving eye health in the region.

As the interview was largely conducted in Vietnamese, Placebo would like to apologise in advance for potential misconstrued statements or inaccuracies in the following translated transcript. Many thanks to Viet Huynh Ba (Communications Manager, FHF Vietnam) for his help.

Placebo: Hi Dr Ang, thank you for speaking to us today. Could you tell us a little bit about your background? What made you want to study ophthalmology?

Dr Ang: It was around November 2010, soon after I began working [in the Cu Giut District Hospital], that the idea of becoming an eye doctor was cultivated. The first thing that struck me by the initial few months of working was that although the number of patients who presented with eye problems were many, the hospital did not have the treatment or expertise available to treat these eye conditions. These patients would travel long distances to get to the hospital, thirty to forty kilometres even, only to find they had to wait for hours in vain. I saw conditions and early presentations that in hindsight could have been easily managed with the right sort of skills and intervention.
Seeing in person how lacking my hospital was when it came to eye health was a strong motivating factor. I began to act in earnest midway through 2011, doing my research and applying for ophthalmology training. However, my original request to proceed was rejected due to limited resources and a long application waiting list.
Eventually in 2013 I was given approval and accepted for training, thanks to The Fred Hollows Foundation. That I was ecstatic to receive this news is an understatement.
I tried not to take it for granted, gaining as much experience wherever I could during my training years. Looking back, I have no idea how exactly I came to follow this pathway as I did not originally have much experience or really know what ophthalmology would entail – it was a series of events, one after the other, that led me to this point. All I had in mind was the desire to gain the skills required to help a large population that was in need.
Within 6 months of training, I was able to see the impact my newly-gained skills had on others. The feelings I've felt from being able to treat my patients cannot be put sufficiently into words. Right now I am very happy – happy for them, happy to be where I am now.

Placebo: How did FHF help you with your training? By comparison, what would have it been like to train as an ophthalmologist in Vietnam without the Foundation's involvement?

Dr Ang: The hospital where I currently work in Dak Nong province was the first one in the region to have received the Foundation's support. I'm not sure how long ago that was, but this hospital was the first. And now there are a few hospitals in the region that also receive support. Fred Hollows Foundation personally helped me from "A to Z". Beyond the ophthalmology course itself, they helped me in virtually every other aspect: my food expenses, accommodation, travel costs, textbooks and resources. They have been very good to me. They helped me turn my dream into reality. Their help and involvement in Dak Nong, allowed me to become the eye doctor I am today.

Placebo: Many Western doctors and NGOs are interested in improving healthcare in the developing world, but good intentions don't always translate into positive results. What kind of assistance is most needed and appreciated by Vietnamese doctors?

Dr Ang: If you are talking about support, I'm not very familiar with places outside my province, but in terms of Dak Nong at least, I know we really need the help. I don't think there would be any person who, regardless of province, would refuse help, whether from governments, from NGOs or from those in a more privileged position; help is highly needed. To say that Vietnam as a whole is greedy for help is correct – but this is because we so desperately need the support.
There are two kinds of assistance we greatly appreciate. Firstly, financial support through funding opportunities. Secondly, professional support in terms of more training in the specialties.

Placebo: Can you tell us more about some of the major challenges doctors in Dak Nong face today, and how they can be overcome?

Dr Ang: To put it simply, everything challenging for us revolves around finance and lack of resources. I talked earlier about our province's need for specialist development through doctor training. There are a lot of doctors who want to train further and pursue specialty pathways, but because we don't have the money or connections like many doctors do in metropolitan hospitals, we struggle to break past those barriers. Doctors have to continue practicing to hone their skills. Those who want to expand knowledge, train higher and gain skills struggle to be accepted into the major hospitals for specialty training, regardless of how we've scored on exams. As there is low funding and a long waiting list, without external support I myself might have had to wait until 2018 to be accepted for ophthalmology training.
Another thing is, unsupported doctors don't generally wish to work in remote and rural areas like Dak Nong, Therefore, when you receive a job you didn't originally set out to do – that is a difficulty. To be able to specialize, I had to leave behind my hospital in Dak Nong and work at Cho Ray Hospital for a while. And even during training, I found that I would need to purchase equipment I could not afford, and after training and upon returning to my hospital, I found I didn't even have some of the right equipment to be able to practice properly since we are so under-resourced here.
So not only is support needed for further training, but doctors and clinical staff here who have already trained also need to be supported in the hospital with adequate

resources. This is not just about helping doctors, but more so the patients and wider population.

Placebo: You've been working in Dak Nong province for six years now, and you've been an ophthalmologist for about three years. What sort of work are you doing at the moment? How would you describe the patients you treat?

Dr Ang: I treat all types of patients. From neonates to elderly people, I see them all. And although I am an ophthalmologist, at the core I am a doctor, and therefore not only do I oversee ophthalmology cases but I have to be able to oversee a variety of medical cases. I've occasionally had to assist with births overnight. The patients I meet come from all walks of life, and I get exposed to all sorts of conditions.

VIETNAM

1,011,556 people screened
53,403 eye operations and treatments performed including:
- 28,300 cataract operations
- 470 diabetic retinopathy treatments
- 24,633 other sight-saving or improving interventions

2,967 pairs of glasses distributed
5,681 people trained including:
- 14 surgeons
- 31 clinic support staff
- 3,821 community health workers
- 1,061 teachers

One facility renovated
15 facilities equipped
$408,936 worth of equipment supplied
174,143 school children and community members educated in eye

Placebo: Can you recall a particular patient, or moment in your career, that more than any other justified your decision to do ophthalmology or medicine in general?

Dr Ang: There are plenty of patient cases over the years I will never forget. However, my first ever ophthalmology case has always remained a special memory. I'd returned to the hospital after graduating from my ophthalmology training course. There was a child who was previously known to the hospital for a recurrent eye growth. The child had presented so many times at different clinics and hospitals before my training – the case seemed almost hopeless, with multiple flare-ups and failed treatment. This time around it had been growing for quite some months again. I saw the patient and said, "I have a way to treat this so it never grows back again." After one week of treatment, it had completely healed. A few months later, the child's mother saw another doctor and told them how it had never grown back. When I heard about that, I felt overwhelming happiness, like I'd won the jackpot.

Placebo: What aspirations do you have for the future?

Dr. Ang: I won't talk about the distant future. Rather, my current aspirations are to continue training up my skills in as short a timeframe as I can, so that I can return and help my relatives and family in my home province. In terms of healthcare in the region, I feel that there are many eye conditions which aren't worth the travel to distant provinces for adequate treatment. My desire is to prevent patients from having to travel such long distances elsewhere, and be able to prevent eye problems in my patients – for example, if we can promote early intervention in glaucoma, we can reduce the risk of future blindness. The support provided by The Fred Hollows Foundation really gives us motivation and allows us to focus entirely on honing our knowledge and improving our skills, rather than financial burden.

Placebo: How do you hope to see healthcare in Vietnam change in the next twenty years?

Dr Ang: Ultimately, my hope is that our health system will not only focus on improving eye health alone, but also all health in general. I hope that one day Vietnam will have one of the best and most efficient healthcare systems, where patient needs are met and there is nothing lacking for them and their health. My dream is that health funding will meet patient needs, to the point that patients will no longer have to pay for healthcare, since good health is a fundamental human right.

Placebo: If someone asked you why they should support the work of the Fred Hollows Foundation, what would you tell them?

Dr Ang: To turn the question back around, I suppose I would ask them, why wouldn't you support Fred Hollows Foundation? Why wouldn't you donate to an organization that trains eye doctors efficiently and improves the lives of disadvantaged patients? Without The Fred Hollows Foundation, patients with eye problems would not only have to cover the costs of travel, accommodation, but then they would also have to pay for healthcare. Because of the work of the foundation, not only do patients not have to pay, they essentially receive pay - they get to see with their own pair of eyes.

Placebo: Finally, Dr Ang, what advice do you have for medical students and aspiring doctors?

Dr Ang: To all those who have faith, virtue and ability: all you need is to continue dreaming.
No matter how good of a student you are, or how intelligent, studious or inquisitive, only dreams and a vision can help you become the best kind of doctor.

MATT HAYES, GEMP 2
ADELYNE HUYNH, GEMP 3






Why Global Health Should Be Taught in All Medical Schools

In medical school we are fortunate enough to have a gamut of experiences in our career from day one. While most experiences are forgotten, many teach us valuable professional lessons that we will remember for the rest of our lives. These experiences always meant one thing to me: global health. My first exposure to global health was as a first year on a volunteer placement with the Flinders Global Action Project (FGAP) in Kathmandu, Nepal. I was placed with the plastic surgery team, which mainly assisted burns victims and children with cleft lips/palates. I didn't think burns would be a major health issue in a place like Nepal, but within a few days I began to understand how integral this plastics team was to the hospital by changing the lives of thousands of people. It dawned on me that I was clueless about the health issues in nations outside of Australia, and it was at this moment that my curiosity about global health was born.

The ideal health professional has a strong understanding of health, is aware of the society of which they are a part of, and can adapt their skills according to their patient population. Scholarly attention to international health and global health has grown exponentially since 1970. Although it is a widely used term, the definition of global health appears to be quite dynamic in nature. Kickbush defined global health as 'those health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people'. Koplan defined it as 'the area of study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide'. Despite the slight disparity among definitions, it is clear that the main goals of global health are 'health for all' and 'health equity'.

In the world we live in today, future doctors must understand global health in order to be well prepared for the complex challenges they will face. Populations have changed in the last few decades with large-scale travel and migration involving patients and health professionals alike. Diseases no longer remain within national boundaries as made evident by the global pandemic of non-communicable diseases such as ischaemic heart disease, chronic obstructive pulmonary disease, and diabetes. It is important to understand social and economic determinants of health in both developed and developing nations in order to understand why specific groups in the population fare worse than others. The benefits of integrating global health teaching into medical education include opportunities to develop a better understanding of refugee health, which, in Australia, is a hot political topic and a whole new patient population that doctors will need to cater for. Not only this, but students are able to have a wider understanding of health.

There appears to be a lack of consensus about what the core components in a global health curriculum should be. This is likely due to the fact that global health has a very broad and varied definition. Johnson et al. proposed that global health teaching should focus on six central themes:

- Global burden of disease
- Socioeconomic and environmental determinants of health
- Health systems
- Global health governance
- Human rights
- Ethics
- Cultural diversity and health

Current literature focuses on the opinions of students and whether or not their curriculums include satisfactory global health education. Focusing on this alone is not enough to inform decisions about global health education. Curriculum committees as well as the educators involved in teaching global health should also be included in the discussions. It is important to understand that learning about global health is a two-way street. We need input from the nations we want to study about and liaise with them. This way our knowledge comes directly from the source and so informed solutions for a country's global health issues can be fruitfully discussed.

Although global health education cannot be introduced into curriculums overnight, we need to acknowledge its ability to make us better health practitioners. For the time being, I encourage you to seek out your local FUSA student groups / clubs that focus on global health, attend conferences or seminars such as AMSA's Global Health Conference or GlobalEx, and, if possible, take part in a volunteer program during the holidays that allows you to gain rich learning experiences about health in other countries. Your global health journey begins now.

ANN THERUVIPARAMBIL, GEMP 4

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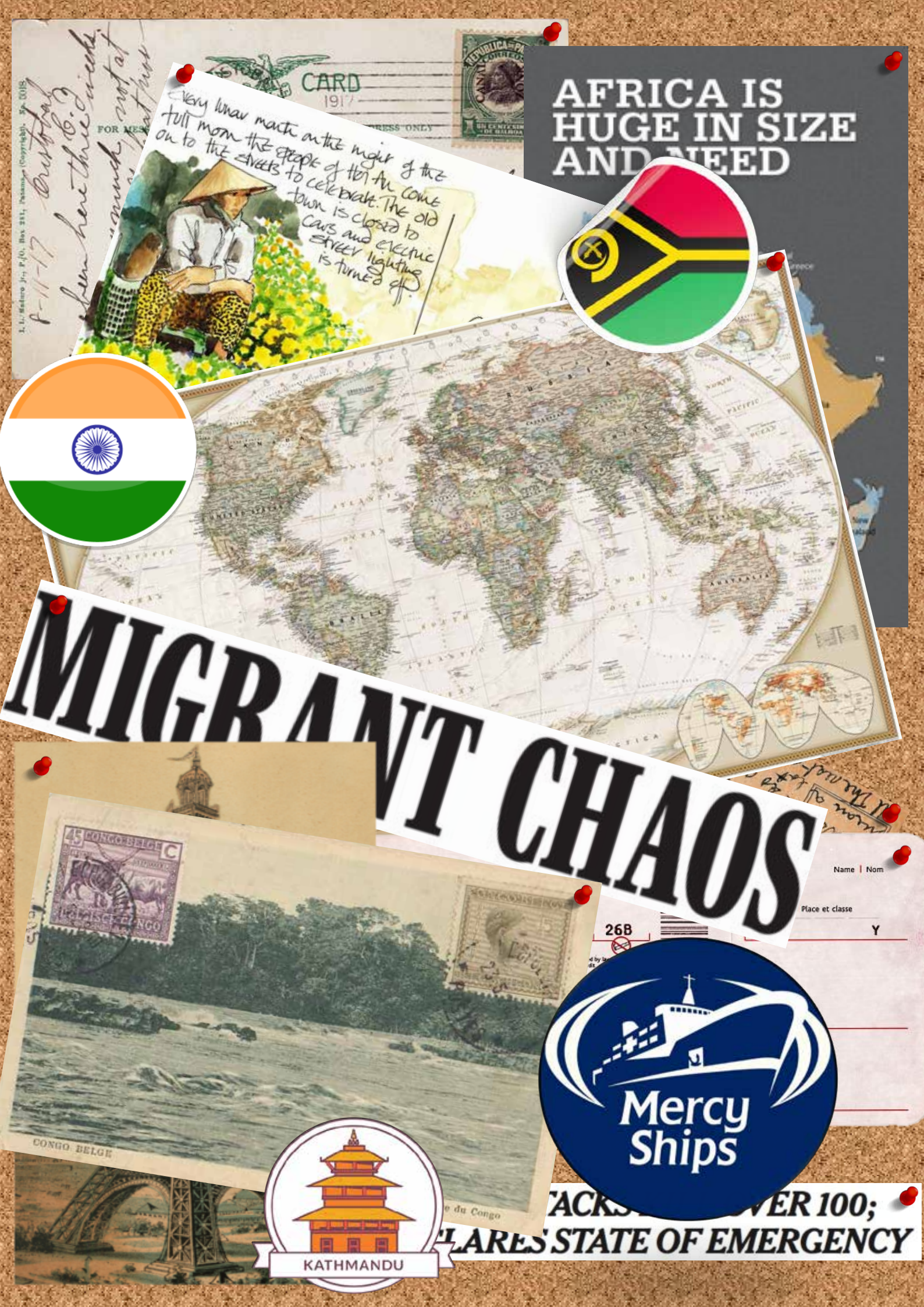
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amsa global health

"Serving the global health interests of Australian medical students."

The Australian Medical Students Association (AMSA) is the peak representative body for Australian medical students. It focuses on advocacy and engagement to ensure that future doctors are informed about and familiar with issues affecting the healthcare system and their careers.

Health has never been more globally connected. AMSA Global Health is a committee of AMSA that aims to engage and empower medical students to take action on global health. It coordinates a range of activities, including campaigns, projects, and conferences, and is represented by 20 different global health groups. The Health and Human Rights Group (HHRG) at Flinders University is one of them.

Major initatives run by AMSA Global Health include Code Green, Crossing Borders for Health, and Red Party. Code Green provides medical students and doctors with an educational platform to inspire colleagues and the community to act to prevent Climate Change. Crossing Borders is an international network of medical students helping to remove barriers to healthcare for refugees, asylum seekers, and undocumented migrants. Finally, Red Party aims to engage medical students with issues surrounding HIV/AIDS through educational and fundraising events, which particularly emphasise countries in sub-Saharan Africa where HIV/AIDS is endemic.

The biggest event of the year for AMSA Global Health is the annual Global Health Conference (GHC) taking place in Newcastle from the 26th to the 30th of August 2016. Medical students from all over Australia will gather to listen to incredible speakers from a variety of backgrounds, and be inspired to strive for health equity and change in our world.

You can email ***globalhealth@hhrg.org.au*** with any questions.

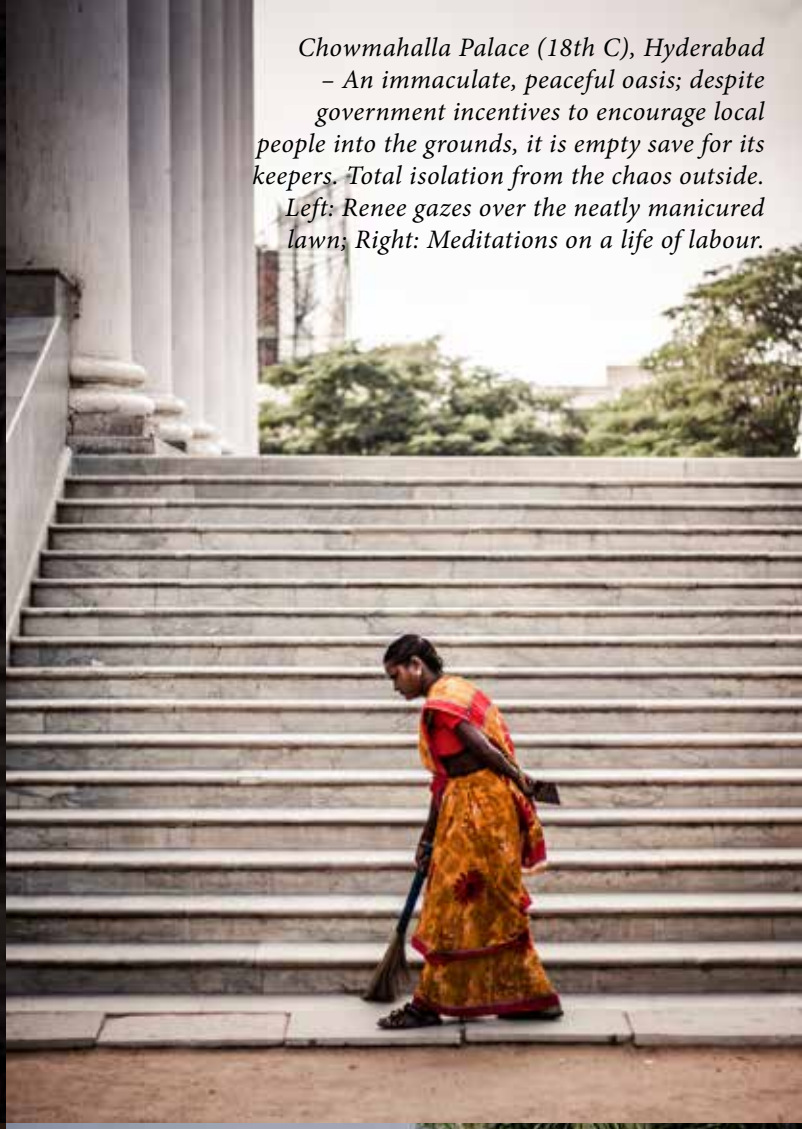
ANN THERUVIPARAMBIL, GEMP 4

FGAP 2015: India

Three of us (Mekha, Renee and I) elected to go to India for FGAP 2015 – the placement was at Medical Trust Hospital, Kochi, Kerala, in the south of India. This photo essay documents the trip from Hyderabad, through Goa, down to Fort Kochi and ultimately to the placement.

Hyderabad – temperate, urgent, desperate, hostile

Chowmahalla Palace (18th C), Hyderabad – An immaculate, peaceful oasis; despite government incentives to encourage local people into the grounds, it is empty save for its keepers. Total isolation from the chaos outside. Left: Renee gazes over the neatly manicured lawn; Right: Meditations on a life of labour.



Chowmahalla Palace – The work is ceaseless while overseeing the UNESCO heritage-listed site.

Top: Benaulim Beach, GOA – Leaving the I.T. capital of the world behind, with all its rampant capital endeavour, we arrive deep in the jungle. Sticky, fresh, friendly, slow, close, nowhere.

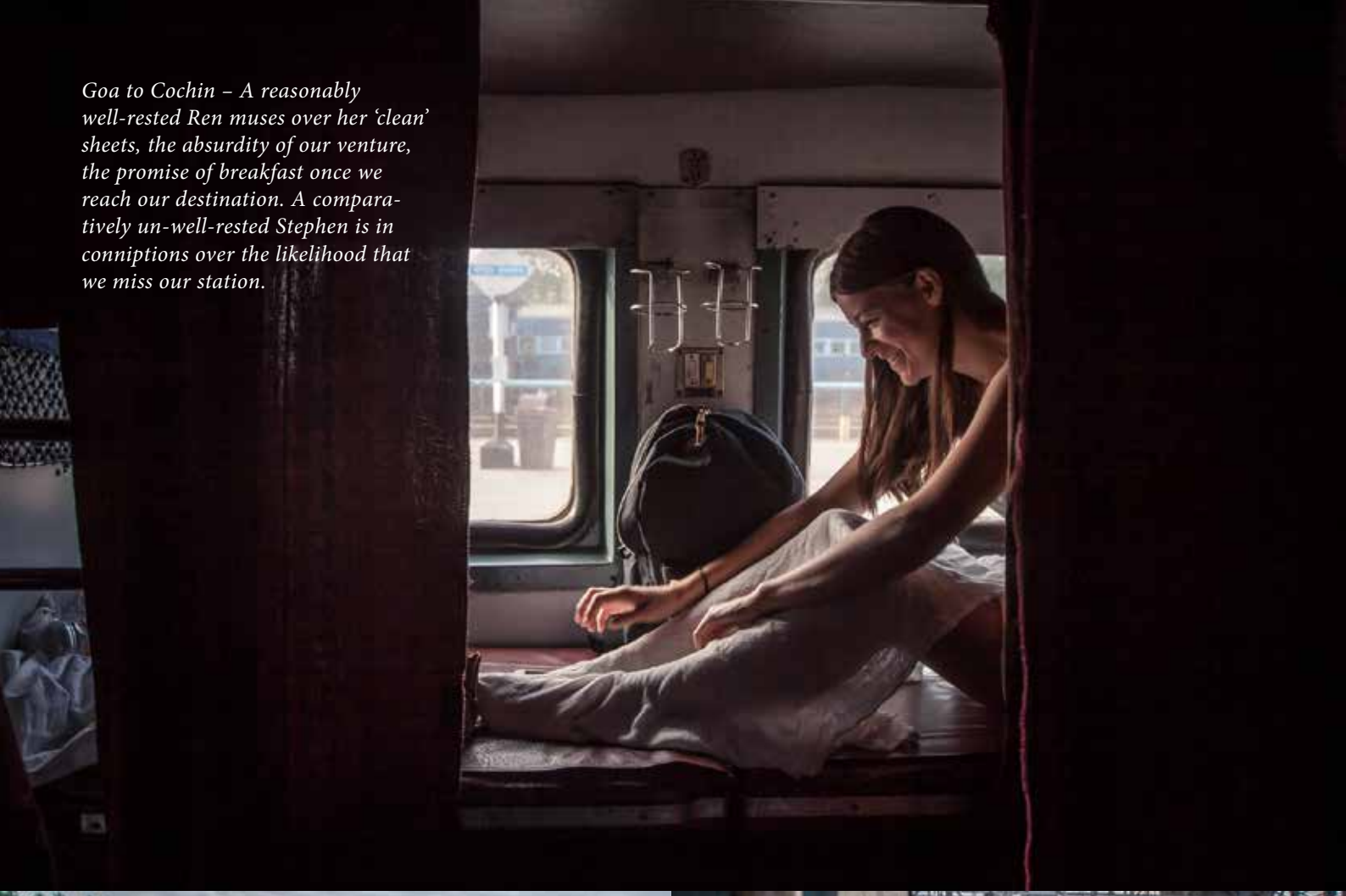
Agonda Beach, GOA – Ren finds her centre in the pristine Goan oceans

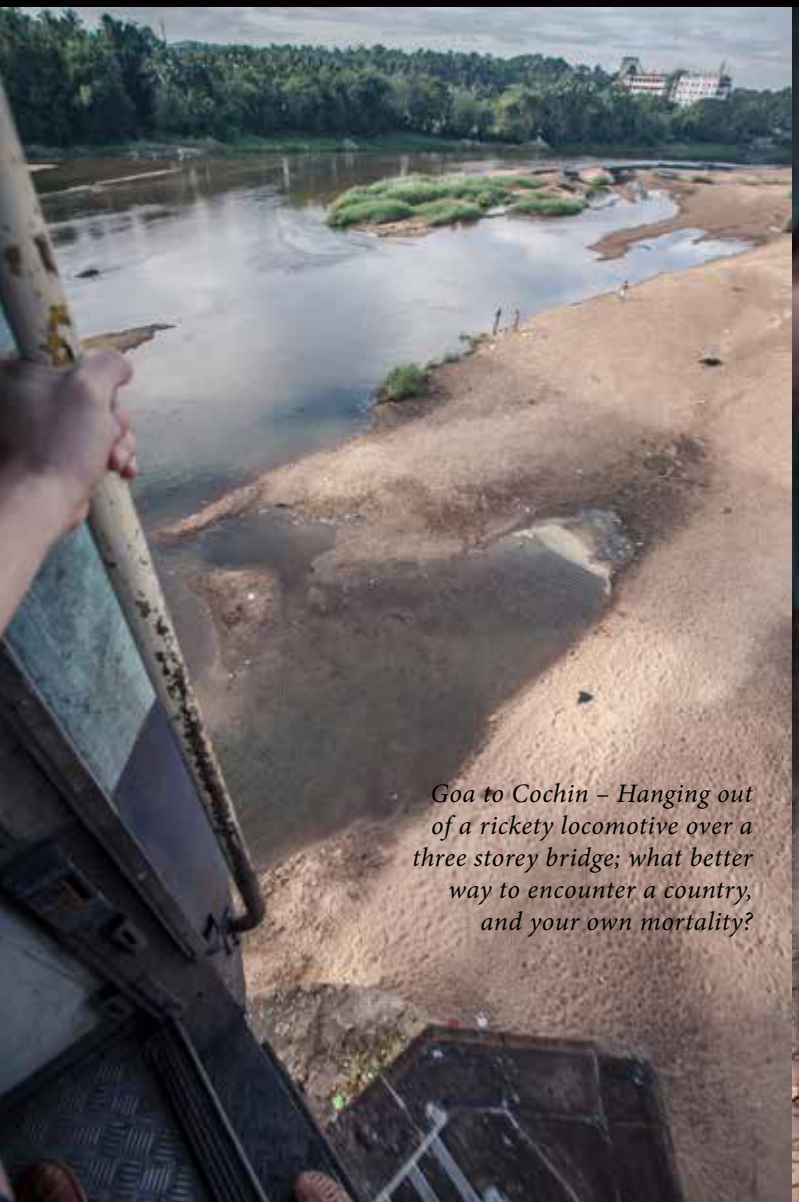
Baroque Church of Our Lady of the Immaculate Conception, Panjem – Street artist takes 5 in the sun; we've just eaten traditional Goan prawns for the fifth time in three days, the sun is sharp, there is no breeze, even the occupants of the town centre move in slow motion.

Field, Goa – Meditations on a life of labour.

Bom Jesus Basilica, North East of Panjem, Goa – School excursion with da bois / The main cathedral is cavernous: imposing, cool, humid, alive, reverberating.

Goa to Cochin – A reasonably well-rested Ren muses over her 'clean' sheets, the absurdity of our venture, the promise of breakfast once we reach our destination. A comparatively un-well-rested Stephen is in conniptions over the likelihood that we miss our station.





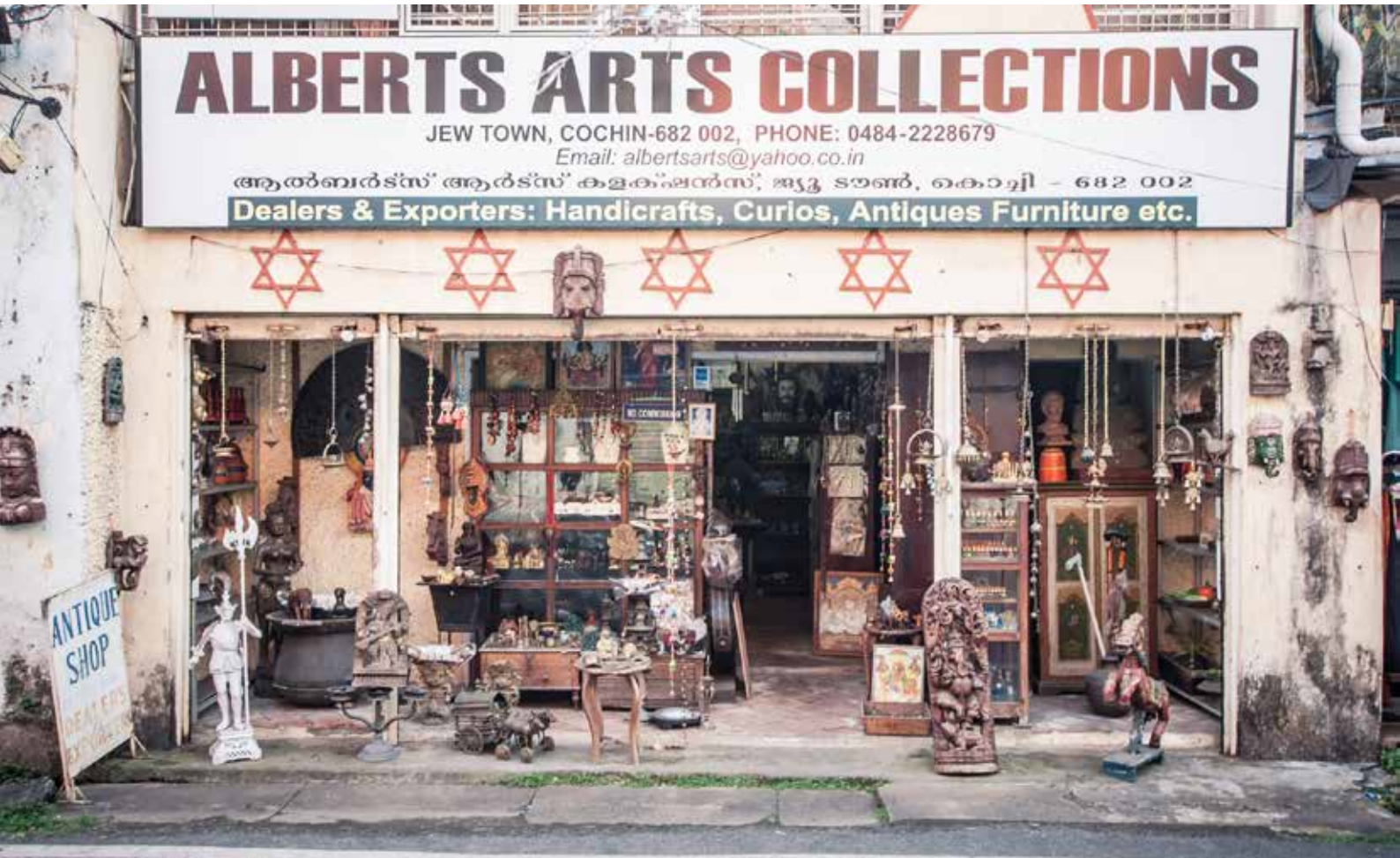
Goa to Cochin – Hanging out of a rickety locomotive over a three storey bridge; what better way to encounter a country, and your own mortality?

Benaulim Beach, Goa – The people are only half the story. Animals both domestic and wild stalk your every step in India; while undomesticated native and colonial breeds patter nervously along city streets, this Daschund 'guarding' a gated manor represents a significant financial investment for her family.

Backwaters, Kerala – A week in to the placement, Mekha's family organised a day trip on a houseboat. Fresh fish – caught, cooked and served – before an endless afternoon sun over infinite skies, impossibly reflected in the water; carrom board showdown, bliss.

Fort Kochi, Kerala – The laneways are beautiful, dense with the mark of humanity, culture, and community, but also innumerable, unmapped and unnavigable. Good luck finding your accommodation.

Fort Kochi, Kerala – Kerala is largely Christian, and politically Communistic in ebbs and flows; Fort Kochi retains an insular, capitalistic Jewish minority with a beautiful heritage-listed synagogue as its centre of faith and community.



Fort Kochi, Kerala – the heavily developed wharf and port suburb still retain great spectacles of nature amidst the Portuguese and British colonial architecture. / Baby girl finds the white guy a spectacle in his own right.

Fort Kochi, Kerala – Karthy was our autodriver, became our personal chauffeur, would drive a half-hour to return even five rupees change to a person if he'd made an error; shared his livelihood, his stories, his life with us. Our angel.

Morning commute to Medical Trust Hospital (MTH) – "Stephen, it's 7am. What are you doing?"

Guards would welcome me with a salute, escort me to the consultants' lift, and glare menacingly at any outpatients attempting to approach us – entire corridors of nursing students would immediately be afflicted by a most irretrievable hush, and part immediately if I were headed in their direction, only to erupt into (surely the cruelest) laughter the minute I made it through that Guard of Pseudo-Honour. Each day was a microcosm of culture, education, misrepresentation, patients' successes and tragedies, the essential nature of hours-long lunch breaks to book-end long mornings and long evening placement, constant discovery, constant self-evaluation, tremendous suffering, limitless joy.

MTH – An imposing, austere structure – filled with life, order, chaos, negotiations both desperate and inconsequential – hot, teeming; rarely peaceful, labyrinthine, classist, severe, dramatic, comic: home.

MTH, OB GYN outpatient clinic – A boy leans in to examine the extravagant Catholic shrine at the heart of the hospital; nurses would ritually stop and sing at the door. Marble lines the floors, the air-conditioning is absolutely triumphant in here, and by 9pm, all but one outpatient has been seen to.

MTH staff – The doctors were as varied as the states in India from which they came – here a young, successful, brilliant but unsatisfied and jaded plastic surgeon enjoys an elaborate lunch with us in a nearby international hotel. The OB GYN team formed a home-base for us and, once we had earned our way into their good-graces, taught us much, generously involving us in holistic patient care, taking me in to an emergency C-section (mother with third degree heart block) and ultimately affording us a window into their good humour, their selflessness, their intellect and curiosity, and their humanity.

The adventurer that expresses itself in each of us while vacationing would triumphantly emerge on days off, and found, nestled away and off a quiet lane, this exemplar of How To Do An Outdoor Basketball Court: smooth, grippy surface, perspex backboards, sprung and netted rings, good light day and night, and, although I protested madly, insisted wildly, the YMCA simply would not accept any further tariff I attempted to pay to use the court by my third day there. Come around sundown, ten million children descended on the court and I naturally found myself clapping and shouting and organising drills while parents amusedly looked on. Classic white boy neocolonial moment.

Fort Kochi, Kerala – The Fort was our home for the few weeks we were in Kerala – it boasted good proximity to the CBD and the hospital, but with its own quaint colonial architecture and (sadly) a clear tourist area, it yet provided some of the best food in the region and was itself absolute agony to leave. Harder still it was leaving the matron of our accommodation, Sheeba Aunty, who took Renee, Mekha and me firmly in to her home and treated us as more than family; as if she had a personal obligation to each of our parents to provide that kind of care which is a pure expression of mothering and of love, distinct to that expected for even her own children.

MTH, BBJ – Do not let this wonderful man's gentle smile and effete features fool you. He was fearsome, and feared by his nursing staff and patients alike. A medical generalist, he played the role of a GP, although within a hospital – a system with some interesting elements, as he was able to admit, monitor, reassess and discharge patients, where, in our system, endless referrals would impede that same patient's progress. Doctor Babu John Matthews, 'BBJ', was one of those singular characters whose dedication, discipline, generosity and love of teaching was hidden beneath a steely exterior that demanded efficiency and absolute perfection. He would hiss, snap, slap, click and scoff his way through ward rounds, patient histories, and – God forbid – an awkwardly exposed abscess, in the never-ending cycle of patients whose own health narratives were so incongruent with this man's clear directives, and yet he nevertheless gave to each patient, each "case", his entire intellect, and his entire heart.

A role model, inspiration, and de facto spirit-animal to the FGAP INDIA 2015 team.

STEPHEN MCMANIS, GEMP 2

SOCIETIES - FGAP NEPAL

In December 2015, I travelled to Nepal as part of a group of first year medical students from Flinders University. The trip was organised by the Flinders Global Action Program (FGAP), which is a branch of the Health and Human Rights Group (HHRG). We each participated in a two-week placement in Kathmandu Model Hospital (KMH). One at a time we were placed in a department – the specialties included emergency medicine, general surgery, paediatrics, obstetrics and gynaecology, internal medicine, orthopaedics, and anaesthesiology. I spent my placement in the emergency department.

Even though we only worked 5-hour shifts, we came home each afternoon just as tired as we were inspired and excited. One of the highlights of the placement was the opportunity to learn from Dr Manoj, the paediatric surgeon who was also the mentor for the group and the teaching coordinator for the hospital. His approach to patient care was calm, compassionate, and holistic, as was his approach to teaching. One of my favourite experiences was when Dr Manoj collected Georgia and me from our hotel late at night to observe an emergency paediatric laparoscopic appendectomy back at the hospital – a procedure not performed by any other surgeon in Nepal.

We were able to deliver a new 12-lead ECG machine to KMH on behalf of the Goolwa Lions Club in partnership with HHRG. This will be put to use in the operating theatres. We also had some fundraising money set aside in case we observed a need for something else while we were there. Speaking to the doctors, we found out that they needed a paediatric IV infuser pump, as they are planning to establish a neonatal ICU. When we arrived they only had IV pumps for adults – these cannot deliver the fine doses needed for babies. It was wonderful to help them purchase this piece of equipment as it will allow them to improve the care already being provided and increase the scope of patients they are able to help.

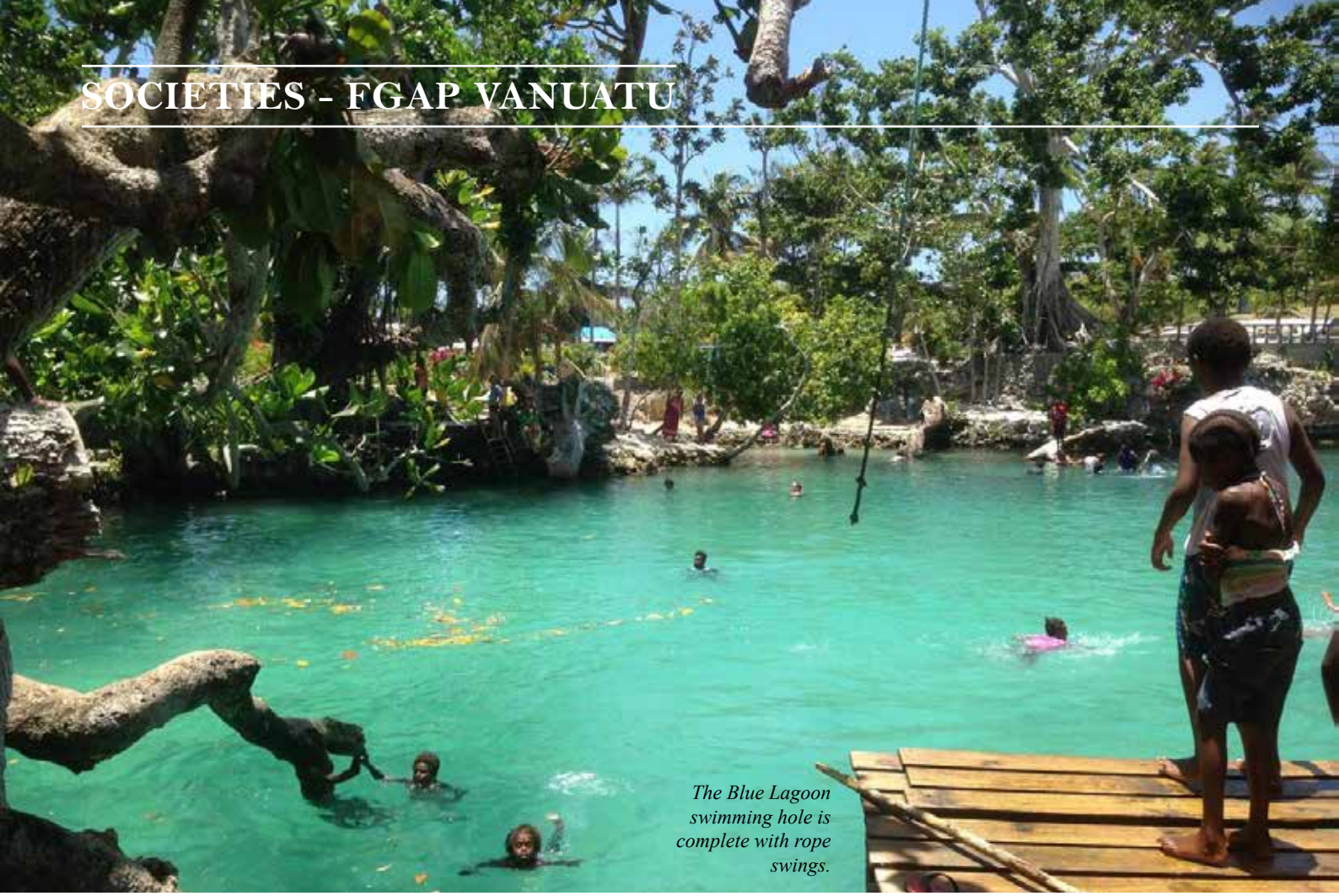
Another interesting experience was to witness firsthand the effects of the fuel crisis in Nepal. A range of complex political issues affecting the Southern border, including conflicts between ethnic groups and protests against Nepal's new constitution, had resulted in a fuel blockade between India and Nepal. While food was generally allowed through, other essentials such as medicines and earthquake relief materials were also blocked.

The blockade ended in late February but lasted five months, with hospitals beginning to run out of medicine during our stay. Thanks to a forward-planning pharmacist, KMH had enough left for a few months but other health services were beginning to struggle. Fuel prices reached the equivalent of $5 (AU) per litre and some of the doctors were no longer able to afford enough to run their cars. A far milder manifestation was how long our dinner took to prepare at restaurants as kitchens resorted to wood fires – we often didn't have time for lunch at the hospital so for us it was the most apparent effect of the shortage! This was just a taste of how much the locals were struggling.

It would be lovely if, within the four walls of the hospital, doctors could shut out political issues and provide high-quality patient care regardless. In reality, the provision of healthcare is often at the mercy of changing political environments, even in Australia. We were reminded how important it is to understand not only the health-related problems faced by a patient, but also the social and political challenges affecting their lives. As a future healthcare provider, I think it is important to defend the rights of patients to quality care. Doctors are often needed to act as advocates for their patients. In this day and age such advocacy may not just be on a local scale, but on a national or global scale too.

There are a range of perks to being a medical student – among them is the fact that people in the community often lend us a certain level of credibility and trust. HHRG and FGAP are a chance to put this to good use and act as advocates for patients, fight for better access to quality care, and act as a voice for the voiceless. Travelling to destinations such as Nepal allows us to understand what this truly means on a global scale and to bear witness to the struggles of doctors and patients in far more difficult environments than our own. As well as learning some medicine, we also learn humility and empathy and are able to give something back to the communities through fundraising, donation of resources, and a mutual exchange of knowledge. We hope these experiences will make us better doctors in the future, and better global citizens now.

CASSIE DRISCOLL, GEMP 2



The Blue Lagoon swimming hole is complete with rope swings.

Vanuatu is the ideal island holiday destination. The untouched natural beauty spans 82 islands and is simply spectacular. Even on the more developed islands, it is easy to find pristine beaches, incredible snorkeling, and even opportunities to hike up active volcanos. The local cuisines, prepared with fresh seafood and tropical fruits, are delicious. Even the Vanuatu delicacy, 'flying fox' or bat, is quite nice, if you can summon the courage to taste it!

Under the idyllic surface of this developing country, however, there is a rawer side. As one of six Flinders medical students who spent two weeks on placement at Port Vila Central Hospital on the main island of Efate in December 2015, I was fortunate enough to also experience this side of Vanuatu. As memorable as my experiences as a tourist were, what I witnessed in the hospital was far more striking and unforgettable.

Walking through the wards for the first time, my eyes began to pick up on the differences between this hospital and the halls of Flinders Medical Centre. Most noticeable to me was what I could not see; the lack of resources was quickly evident. Thermometers and blood pressure cuffs are scarce. The leads of outdated ECG machines attach using rubber suction cups, not disposable electrodes. Rubber gloves are used as tourniquets rather than for hygiene purposes. Chest tube wounds are covered with a piece of gauze and sports tape instead of proper bandages. The only two painkillers stocked in the paediatric ward, where I was stationed for the majority of my placement, are aspirin and morphine. Unfortunately, their supply rarely matches demand, and it was routine to see paediatric bone fractures set without pain relief. At times, it was surreal to watch doctors and nurses practice medicine without very basic supplies – supplies that I now realise are taken for granted in Australian hospitals.

Of course, I knew that I would be exposed to a certain degree of health disparity while working in a hospital in a developing country. I was not prepared, however, to witness some of the cases admitted to the paediatric ward. It was not uncommon to see patients with severe malnutrition or potential tuberculosis. Nearly all cancer patients are immediately designated as palliative because chemotherapy and radiation services are not available.

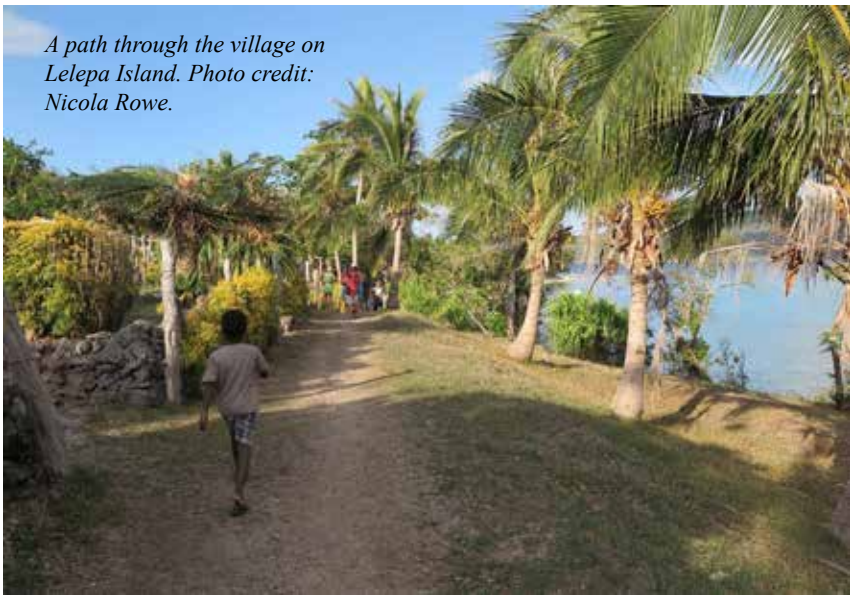
Perhaps the most striking story was that of Sasa, a 12-year-old girl with advanced chronic rheumatic heart disease. After a bout of acute rheumatic fever early in her life resulting in the hardening of her heart valves, Sasa's heart slowly began to fail over the next few years. Upon admission to the hospital, her weak heart was beating rapidly in order to pump enough blood to her body, and the build-up of fluid in her lungs made breathing difficult. Even to my untrained ears, a heart murmur could easily be heard with a stethoscope. It was almost unbelievable to see the physical signs of this severe disease, one usually reserved for textbooks, in such a young girl. In Australia, whenever cases occur in remote communities, they are treated with appropriate surgical intervention. By contrast, following her stay at Port Vila Central Hospital, Sasa was sent back to her home on an outer island with instructions outlining her palliative care.

These are only a few examples of the, at times, dire realities of the Vanuatu healthcare system. But despite this, the citizens of Vanuatu are incredibly happy people and enthusiastically extend this friendliness to visitors. It is impossible to walk even a few minutes without hearing a cheerful, "good morning" or, "goodnight". Children run up to you in the streets wanting to play; they even sit on the fence surrounding the airport, waving goodbye to planes as they take off. While the details of what I experienced in Vanuatu as a tourist and as a medical student may fade, it is because of gestures such as these that I will always remember how welcome I felt in Port Vila.

AMANDA CIOZDA, GEMP 2

A home on Lelepa Island, a short boat ride from the capital city of Port Vila. Photo credit: Nicola Rowe.

Banyan trees are massive; they can grow to about 30 meters. The locals hide in these trees when cyclones strike.



A path through the village on Lelepa Island. Photo credit: Nicola Rowe.

Ambulances outside of Port Vila Central Hospital in Vanuatu's capital city of Port Vila.

This is Havana Beach on the main island of Efate. Across the water is Lelepa Island, which is where Survivor Vanuatu was filmed.

A fireshow put on by students from a youth performance group.

The local delicacy is 'flying fox', also known as bat. Here it was prepared in a French style bourguignonne sauce. It tasted quite nice, but the presentation was not as appealing. Photo credit: Nicola Rowe.

The 24-hour food market in Port Vila, where farmers bring their produce from around the the island of Efate to be sold. Photo credit: Nicola Rowe.

INTERNATIONAL STUDENTS OF FLINDERS

FMSS will shine the spotlight on one fourth year international student's journey to and through medical school each week. Our International Students' Representative, Laalithya Konduru, will have a tête-à-tête with the student and publish their story on Facebook in a feature called The International Student Spotlight. We will also be publishing selected interviews on Placebo. To kick things off, here are the stories of Krishin Nandwani and Veronica Corotto, our two previous International Students' Representatives.

KRISHIN NANDWANI, GEMP 4

I'm from Singapore. I was private tutor for a couple of years and used the money I earned to travel around Asia and Australia for a year. Prior to committing to medicine, I was confident that I did not want to work a desk job. I found my time as a medic in the Singapore army to be pretty fulfilling and decided a career in medicine would be fun. With that said there were times in third year when I cursed my past self for being so cavalier with the word "fun". At this stage, I feel that the motivation has not changed and that I have chosen a career path that makes me feel good about myself.

The one thing I gained at Flinders which I think I would not have gained anywhere else is the ability to step into the medical centre at any point during my course and interact with patients. A fair number of people inspire me – colleagues, friends, family and even some TV show characters. I want to be a General Surgeon – wish me luck!

I haven't experienced enough of the world to know where exactly I would like to be but ideally, I want to work at a major city hospital that boasts of a diverse patient load and supportive (and fun) work culture. The location of the hospital itself and closeness to family and friends is a major consideration for me. The internship crisis certainly has made me consider the options I have available to me more than I previously would have.

When I'm not studying, I am catching up on TV shows, reading books and spending time with friends. Once I graduate, I will really miss putting off my loan repayments! If I had to give one piece of advice to my juniors, I'd say, BE PROACTIVE ON THE WARDS!

VERONICA COROTTO, GEMP4

I come from San Diego, USA. Before getting into medicine I completed a Bachelor's degree in Liberal Arts and Sciences with a major in Psychology and a minor in Italian. Besides going to University, I worked in a family business back home. Many things influenced me in choosing to attend medical school – my father and grandfather have Type I Diabetes Mellitus, and therefore I've grown up with medicine in a way. The fact that I find the human body so fascinating and confusing all at once, is another important reason I chose this occupation. I wanted a career I could really enjoy, but one that would also challenge me, and medicine certainly fits the bill.

Without getting too political, I don't agree with the healthcare system in the US and didn't want to be a part of it, so I chose to come to Australia because I could see myself living and working here for the rest of my life. I chose Flinders University because it was a smaller medical school than some of the other ones I applied to. Coming from San Diego State University where my class size was huge, I wanted a more personal learning experience. I had also never been to Adelaide, so I kind of wanted an adventure.

My favorite memory at Flinders was my very first day of orientation as a new student. I had just moved to a new country, in a city I had never visited before, and I felt so vulnerable, terrified, and excited. It was such a huge mixture of emotions.

My initial reasons for choosing to study medicine are still very important to me. I still see medicine as a part of the "family" side of things, and now I also get to be a part of the practitioner's side. I get a nicely rounded view of medicine now which I find very important to keep myself grounded and will eventually make me a better practitioner. Currently there are two different specialties that I can see myself pursuing in the long term – Pediatric Endocrinology and OBGYN. For now, I am just trying to focus on gaining experience and getting an internship in 2017.

I definitely want to stay in Australia after graduation. I am more than happy to move around the country for a while, depending on the training opportunities. The internship crisis has made me terrified that I won't get to practice in Australia. If I had to give one piece of advice to my juniors, I'd say, MAKE TIME FOR YOUR HOBBIES!

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