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# PLACEBO

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## About the Cover

The design of Issue Two 2017 was inspired by The New Yorker, specifically *Operating Theatre* by Malika Favre. Her cover triggered imitations by female surgeons across the globe and will be remembered for many years to come.



*History has a habit of  
changing the people who  
think they are changing it.*

Terry Pratchett, *Mort*

Along with Florence  
Nightingale, Hippocrates,  
Marie Curie, and Louis  
Pasteur, we're contributing to  
an ancient vocation that will  
continue long after we've hung  
up our stethoscopes!



# ACKNOWLEDGEMENTS

The 2017 Editorial Team would like to celebrate our spiffing contributors. We're all sleep-deprived, coffee-fuelled medical students with never-ending to do lists and looming assessments so of course it's difficult to squeeze in some extracurricular artistry. Placebo is a little magazine with gigantic potential; thank you for recognising this. Keep up the good work and stay tuned for 2018. Doesn't time—or history—fly?

Brian Ch'ng  
Casey Welsh  
Georgia Glass  
Harrison Bolt  
Ilze Alexander  
James Cohen  
Jean Pepperill  
Julie Huynh  
Katie Cameron  
Max Deighton  
Michael Robb  
Nathan Lang  
Nirali Patel  
Pamela Gabrehiwot  
Sabrina Razmi  
Sarah McArthur

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





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# EDITORIAL



## ALICE DALRYMPLE *MD2, Publications Director*

History fascinates me. Incestuous Ancient Egyptians, bolshy revolutionaries, and infamous dictators are irrefutably an appealing bunch. But I'm just as captivated by the consequences of decisions. I'm snuggled up in chilly (it's August) Adelaide today because my maternal ancestors moved across the Channel from the then German Alsace-Lorraine, because my Scottish paternal grandmother went to Milan to work for my Sicilian grandfather, because my father joined the British Army to fund medical school, and because my mother met my father on the cardiology ward—how romantic—of the now demolished Norfolk and Norwich Hospital and decided not to nurse in the Royal Navy. I crave Waffeln mit heißen Kirschen when the marzipan begins to sweat on the Christmas cake because a certain moustached maniac marched into Poland and my brother can apply for an Irish passport in the wake of Brexit because of the IRA. It's mind-boggling stuff. And who knows how me saying "yes" today and "no" tomorrow will affect my future...or my children's future...if I even have children...little Ptolemy, Tiberius, and Wolfgang...what if I don't meet my Nobel Prize in Physiology or Medicine-aspiring humanitarian bookworm of a chap? Enough of that.

What I know for certain at this point in my existence is that I'm determined

claim a corner of the operating theatre for my own. The human body is utterly fascinating and I can't imagine going into a speciality where I'm not marvelling at our internal workings every day. My regularly irregular heart has so far squeezed blood into my aorta and pulmonary arteries more than 1 BILLION times. Your brain generates enough electricity to power a lightbulb. And isn't it incredible how a thinking, feeling bundle of potential grows inside another?

Perhaps some of this enthrallment comes from my neurosurgeon of a maternal great-great uncle, William Charles Ravensworth De Jongh. The old photograph is of his wife—my great-great aunt—Olga De Jongh (nee Ferneley). She was born in 1892 and died in 1977 and lived through the British concentration camps of the second Anglo-Boer War, the death of Queen Victoria, the Russian Revolution, women's suffrage and the right to vote, two world wars and the Holocaust, the advent of antibiotics, the collapse of the British Raj, the Korean War, the coronation of Queen Elizabeth II, the first heart transplant, the Vietnam War, "That's one small step for man, one giant leap for mankind", and Luke Skywalker.

I've lived through the Internet, the Bosnian War and Bosnian genocide, the death of Diana, Princess of Wales, Harry Potter, Y2K and the Millennium, 9/11, the Iraq War, the War in Afghanistan, the 7/7 London Bombings, concerns about

antibiotic resistance, and President Donald Trump...so far. scary to contemplate what else I'll live through. Will I witness our first step on Mars? Will we beat cancer? Will THAT tophaceous joke of a leader in Pyongyang trigger a nuclear exchange and turn out not to be so funny after all? At least I'll be in control of my history in Medicine.

I've played some part in the history of Placebo. This is sadly my last instalment. I've had midnight meltdowns over misplaced commas and my lumbar spine certainly didn't appreciate lugging boxes of copies around the campus but I'm chuffed to bits with the work myself and the evolving editorial team has produced over the last 2 years. We mimicked National Geographic in our Global Health issue, took inspiration from Captain James T. Kirk to warp our way into The Future, and cast The Magic of Medicine over FMC. I sincerely hope Placebo doesn't fizzle out. Doctors are Homo sapiens too and not one of us will get through medical school just by regurgitating cold, hard facts. Show your peers and professors what gets you out from underneath your cosy duvet every morning. So Auf Wiedersehen Placebo. I'll write for you for as long as you're published. I hope you readers will too!



# EDITORIAL



## **MATILDA SMALE** **MD1, Publications Officer**

My own history stems from my Dad who grew up in the Mid-North of South Australia and my Mum whose parents migrated to Australia from Malta during the 1950s. I was fortunate to have a rich cultural upbringing, learning how to speak French and Maltese from my Nannu who was born in Tunis, Africa and cooking delicious feasts with my Nanna. Hearing about their stories of living through and participating in World Wars, migrating to Australia by boat whilst still in their teenage years with minimal English language skills and learning to not be scared of their German neighbour upon arriving in Australia (who still remains my Nanna's neighbour today) continues to fascinate me. This is why I find history so astounding, every generation experiences something different which shapes society for years to come.

This edition could be a textbook covering the rich history of Medicine but instead we've compiled some interesting pieces covering a range of topics. It is clear that the History of Medicine is so unique ranging from the study of Anatomy to Rural Medicine in Australia. Regardless of the diverse history, each have played a pivotal role in Medicine today. I find it quite inspiring (but also terrifying) that our individual journeys and the choices we make today will shape our future in both life and Medicine (and perhaps may change the delivery of care for our

patients). Some advice from Dr David David at Global Health Conference was who knows who your fellow classmates will be in the future, make connections now because you may cross paths later in your career.

I hope you enjoy the last edition of Placebo for the year and enjoy the long-awaited and well deserved Summer break.



## **HARITI SALUJA** **MD1, Marketing Officer**

## **ANDREW PHUA** **MD2, Marketing Director**

Medical students are an important part of the medical profession...so the history of Medicine includes the history of medical students and, at Flinders University, the history of Placebo. The design of Placebo has drastically changed since the 1970s; over the past couple of years, each edition has mimicked a popular magazine or journal. This edition is inspired by The New Yorker but reflects earlier editions with its black and white format and casual layout. Despite the changes in design over the years, the content of Placebo has revolved around similar themes of academics and student experiences.

As we explore the history of Medicine in this issue, we also consider our personal histories and choices. It's tempting to find things that divide us, but also enjoyable to find common ground. Wherever we've come from, we are now united in our journeys in becoming doctors. So treasure those travelling together with us; it makes the road far more bearable and memorable.

We hope you enjoy this final edition of Placebo for 2017!



## FROM THE VICE~PRESIDENTS



### **JULIE HUYNH** **MD2, Vice-President (External)**

### **HARRISON BOLT** **MD2, Vice-President (Internal)**

What a year! 2017 began with the introduction of Progress Tests, Team Based Learning, and all sorts of other little changes. It is fair to say that some aspects have been tough, for both staff and students; but all in all, we have taken the changes in our stride. From an FMSS point of view, we have certainly noticed a culture shift within Medicine – which is to be expected when you shift from a cram-style once-a-block-exam assessment to weekly quizzes and progress testing. As we all (including the College) get used to Programmatic Assessment for Learning, we hope that as a cohort we learn how to enjoy the little things along the way, rather than getting swept up in the current of ongoing assessment. It has been through the ongoing efforts of the exec team and year level reps that FMSS has built on our strong relationship with the College to try and influence decisions where possible. We can all agree that there is a lot of work before all the teething issues are worked out, so thank you all for your ongoing support and willingness to communicate through FMSS.

Taking a moment to reflect on the year, it has been a fantastic year for FMSS and the MD cohort.

**Social:** We began the year with the largest Med Camp in FMSS history,

which combined with the spectacularly organised O-Week made for an excellent introduction to Medicine for 2017's MD 1s. Social also held the first cost neutral Med Ball in decades, meaning a more sustainable social budget without compromising on amazing food, music, and vibes!

**Engagement:** Launched a new merch fashion line, with postage, regular pickup times, and all bought in bulk to save students money. It has been a priority of ours this year to strengthen our relationship with the other Med Socs at Flinders, we believe that working together we can achieve a lot more than if we compete – so far we have only seen good things.

**Education:** Continuation of MD 1 peer teaching in the light of PAL, as well as the introduction of MD 2 peer teaching.

**Community:** New benchmarks set with money raised for the Leukaemia Foundation going just over \$9000 and \$1800 for Daffodil Day. They built on last year's amazing work with Teddy Bear Hospital, running a total of three sessions to cater for the demand, as well as introducing new competitions for Vampire Cup to capitalise on that competitive med student nature for a good cause!

**Women's Portfolio:** Continued on the epic build-up of the last 2 years, particularly with the Yarrow Place workshop, and successfully brought Female Genital Mutilation awareness into the MD curriculum.

**Wellbeing:** As mentioned above, this

year and all its changes have been tough on the cohort, so the HW&AD portfolio has been working hard behind the scenes. This is not to mention the massive Mental Health in Medicine night that sparked a lot of interest from the College. We hope that this interest translates into better resources available for medical students going through a difficult time.

Additionally, FMSS has reinvented our Grants programme, introducing Financial Hardship Grants and Emergency Vouchers that are available all year long (or at least until we run out of money!).

We'd like to say a big thank you to marketing and I.T. as a lot of what they do goes unnoticed, but without them, we wouldn't have the beautiful posters, a website on which to sell our merch, nor even a design for this magazine.

We are both looking forward to seeing what the clinical years hold and would like to thank the FMSS committee for being such an incredible team with which to work. We also want to say a massive thank you to our phenomenal President, Anna, who has been a part of FMSS for 5 years now, all while blitzing med and raising two beautiful kids. It is time for her to say goodbye to the FMSS and Flinders Med family now, and we'll miss her dearly. We hope that all our MD 4s have a great life as interns next year and know that the Grad Week team have an excellent send-off planned.

Happy holidays, everybody, and no doubt we'll see you in 2018!



# ACADEMIC



*Dr. Andrew Peacock in Antarctica*

## Histories Start at Flinders

**DR. ANDREW PEACOCK**  
*BMBS (Hons), 1991*

**ALICE DALRYMPLE**  
*MD2, Publications Director*

*Alice contacted Expedition Doctor Andrew Peacock after viewing his entries to the Australian Geographic Nature Photographer of the Year competition at the South Australian Museum. Here's what he had to say.*

**Tell us about yourself and your time at Flinders.**

I grew up in Adelaide and from late primary school lived just up the steep hill from the campus in Bellevue Heights. The bike ride to lectures was super quick, the ride home a bit slower! I started at Flinders when I was 16 years old, crazy huh?! How could you possibly know you want to be a doctor at such a young age? That's the kind of thing that happens when your father is a surgeon—Dr. Morris Peacock (AM) was a thoracic surgeon at Flinders—and mother an ex-nurse. In fact, I was mainly interested in Sports Physiology and sought out Neil Craig, former coach of the Adelaide Crows, to ask

his advice as he was then working as an exercise physiologist and he suggested doing Medicine as a pathway to obtain maximum credentials to work in that area. I often joke that if a career counselor had sat me down at Blackwood High School and asked me about a career in Architecture I naively would have replied “What is that?”!

I didn't find studying at Flinders to be particularly onerous, we had some very good clinical tutors of whom we were in awe, people like Professor Jack Alpers for instance. I was balancing life as an athlete with study and took a year off to compete in Europe at the Junior Sprint Kayaking world championships. Interestingly my best friends and support network there were the so called ‘mature age’ students rather than fellow young ‘high school leavers’ like myself. Being able to study Medical Spanish and Exercise Physiology as elective options was fun as was time spent overseas in 6th year where I met my now wife in San Francisco where she was a principal ballerina with the company there. My elective was spent with the sports doctors looking after the dancers, hence a chance meeting with Sabina.

**As a medical student, did you plan to pursue Expedition Medicine or did the opportunity present itself later in your career?**

I didn't plan anything career wise when I was a student although I was most interested in surgery, especially plastics and hands. I was pretty happy to leave Adelaide for what I saw then as more interesting pastures in Sydney where I wanted to continue competing in Surf Lifesaving competitions at a high level with the North Bondi club. In fact, I only applied to do an internship at locations close to that beach and ended up at the Royal Prince Alfred Hospital, a place that I have no fondness for after an uninspiring year spent there and at one of its peripheral hospitals way out of town. So after sitting the USMLE I left for the US to take up a position as a General Surgery resident and had a brilliant year working in Santa Barbara in California, a place I developed a relationship with on one of my 6th year electives.

At the end of that year I wasn't quite sure that I wanted to keep on with training and coincidentally at that time I took a weekend rock climbing course and really that was the catalyst for an end to any likelihood of a traditional medical career. I loved the mental and physical challenges of the activity and immediately hit the road in the US climbing as often as possible especially in the Sierra Nevada range. I did return to Australia and worked odd locums here and there but always with a view to more climbing trips. Eventually I

volunteered as a doctor for the Tibetan Government-in-exile in Dharamsala in India and then for the Himalayan Rescue Association in Nepal. I guess it then dawned on me that there were opportunities out there for me to combine my adventure skills with medical work and I began leading treks in Nepal and working on climbing expeditions (unpaid) and travelling to Antarctica as a ship doctor. So that's how my involvement with Expedition Medicine came about.

#### What does being a doctor mean for you?

It means that when I go to work in the Emergency Room all I need to be focused on is helping others and that I have a large amount of autonomy in decision-making, which I like. I have flexibility and control over how I live my life for which I am very thankful and I am fortunate to be able to earn an income that allows me plenty of time for other pursuits. Because of my training and experience I know how to listen to people and to relate to people from all walks of life and of all ages. That is invaluable in so many other facets of life and work such as when I am working as a photo instructor for Lindblad/National Geographic Expeditions with 100 guests on a ship.

#### Your photographs of Antarctica are spectacular. Do you have a favourite place in the world?

Thank you! Antarctica is a favourite adventure travel destination for sure. But there are many others too, Alaska and the arctic regions are very high on my list. Often the best experiences abroad are those shared with good friends and I am very lucky to be able to visit and spend time with friends who live around the globe so they are my favourite places.

#### Any sticky situations during your work in Expedition Medicine?

A good recent example on that front was in May this year when I volunteered as a medical ranger with the Denali National Park service to patrol the mountain at the start of the climbing season. I had some significant back pain leading up to the patrol and wasn't as well prepared physically as I would have liked and then I found myself teamed with very experienced and fit ski patrollers whereas my skiing skills are not great! Luckily for me they were very patient and supportive people to work with so I managed to keep up with the tasks at hand...just. Once established at high camp for 3 weeks we didn't have much in the way of medical challenges and to be truthful photographically it was a bit humdrum as well. Things were a bit too exciting on skis as far as I was concerned on our descent day when we traversed the notorious 'Windy

Corner' in high winds and poor visibility with ice rather than snow on the track. Gaping crevasses below the fall line didn't look too inviting and in the end I needed a lot of help from our patrol leader to stop me from ending up in one.

#### Every student takes a different path through Medicine. Do you have any advice for the next generation of doctors...particularly those who wouldn't mind time aboard an icebreaker (hint, hint)?

Oh dear, it's difficult to speak as if I know any answers to that, hopefully you can tell that none of this was actually 'planned' by me! But for those interested in the path less travelled, take the time to work out a specialty path, don't feel pressured into making a decision on that and then only pursue something that you *really* want to do. Life can be too short to waste on something you're not that passionate about. A general

skill set will serve you better—think GP or ED training—than anything else if the outdoor environment is your thing. Try and maintain control over your work hours and responsibilities, nobody said...ever...that working full time as a doctor is the only way it can work. And finally consider coming along to one of the biannual Expedition and Wilderness Medicine courses I run in the Blue Mountains near Sydney

([www.expeditionmedicine.com.au/index.php/products/event/p-00184.html](http://www.expeditionmedicine.com.au/index.php/products/event/p-00184.html))

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**Ditzza Teng**  
 Medical student  
 Member since 2015







*Clockwise from top: Penguin Palace. Arizona, USA. Antarctica. New Zealand.*



# The True History of the General Practice Gang

**DR. PAUL DALRYMPLE**  
**MBBS MRCGP FRACGP MSc**  
**DRCOG DFFP DCCH**

Statistically speaking, two-thirds of you reading this will complete your medical degree and then for one reason or another enter the heady world of General Practice.

Aren't you lucky!

Some of you will embrace this wondrous concept of medical care at the coalface, from the cradle to the grave, or whatever metaphor you choose to justify your career decision. For some of you, however, it will be a matter of stumbling inadvertently into the swampy lowlands of Primary Care having taken a wrong turning somewhere on the way to the dizzy heights of the Ivory Towers of Specialist Medicine.

However you journey into this challenging, rewarding, and yet sometimes demoralising area of Medicine, spare a thought for those first doctors who blazed a trail in this wide brown land and founded what must be the premier discipline that drives the care of our fellow humans today.

But first, you might be surprised to note that General Practitioners evolved not from physicians—who incidentally got their act together 270 years before the First Fleet hit the shores of our great continent, in 1518 with the establishment of the first Royal College—and not from the dreaded barbers and their dodgy cutthroat razors, with their dubious infection control, who took a mere 200 years to catch up with their esteemed physician colleagues before they were recognised less as bloodthirsty maniacs and more as respectable individuals who the public felt comfortable enough with to allow them to slice and dice various segments of their bodies.



No. General Practitioners started their existence as humble greengrocers.

More specifically, the first General Practitioners were grocers who dined with a bit of spice and who in 1617 formed the Society of Apothecaries in Black Friars in London where the society hall stands to this day despite the odd plague, fire, and flood. Of course, their medicines were less evidence-based and more fantasy driven, the first proponents of the Potter School of Medicine!

Did you know, for instance, that the treatment for sciatica then was a spoonful of bile from a red Ox, two spoonfuls of water-pepper, four spoonfuls of the patient's own urine (Ewwwww!), a rather large pinch of cumin, and as much suet as you could handle all boiled down into a broth which would be poured over the painful spot and covered with hot cloths for several days until either the patient got better or mustered the courage to break free and run away screaming for their lives! And if that wasn't enough, never forget that if you come across a minor burn, reaching for the Flamazine today seems less controversial than running into the cabbage patch to retrieve a snail or two to rub over the affected area as was recommended then. To be fair, however, to this last point, research

today is focusing in on snail gel again as a potential wonder cure for burns. So maybe the early General Practitioners were on to something after all... although the idea of treating gout with a plucked, boiled, and then roasted-until-incinerated, ground up owl lightly sprinkled over the affected joint smacks of desperation!

Fast forward now to the First Fleet and just beyond our early settlement. It seems that early General Practitioners were not only specialists in Fruit and Veg but that they also made good crims in the eyes of Mother England. The then British Government thought it would be a splendid idea if convicts being transported to Terra Incognita were accompanied by convict doctors to help meet the growing demands of the first colony.

You may not know but of that First Fleet of 11 ships that sailed 24,000 kilometres with only three stops and carrying a total of 1487 people, only 3% died. That's 48 people! Utterly remarkable given the medical challenges that must have been faced. Ten doctors travelled with the fleet. One for every 150 people on board, dealing with every conceivable problem from scurvy to syphilis without blood tests, imaging, penicillin, or Flinders Medical Centre for back-up! What a truly remarkable feat that



was! But only four doctors stayed on with the transportees. During the transportation period 160,000 convicts arrived in this new world. Of these, 0.07% were convict doctors...that's a mere 112!

The second fleet, it seems, did worse both in morbidity and mortality and disembarked 500 out of 759 sick and dying convicts not to mention the nearly 300 that additionally died during the voyage. That was all down to economics, as always, when payments were made to shipping companies for convicts accepted and not delivered. The already starving and failing first colony must have been overwhelmed by the scale of disease and illness that arrived and one can only imagine the work those early doctors must have done to help save the project.



William Redfern (pictured) was one such individual. He started life as a surgeon. Born an Ulsterman (that's Northern Ireland for you Aussies who are geographically challenged still) he grew up in the beautiful county of Wiltshire in the West Country of England and became an apprentice to his older brother Thomas, also a surgeon. He got caught up in a mutiny on HMS Standard in 1797, was sentenced to death but was spared as he was a doctor, and then languished for 4 years instead in the squalor and filth of English jails before begging transportation to New South Wales in 1801. He was then immediately sent to Norfolk Island—how unlucky could a man be—but was given a conditional royal pardon as an inducement to

return to Sydney and set about his life as a doctor Downunder with vigour and enthusiasm. In Sydney at the behest of Governor Macquarie he became the first superintendent of the 'Rum Hospital' in the centre which now forms part of the NSW Parliament and The Mint. This aptly named institution was established for the care of the convicts. It was founded as a result of a deal between the then Governor and a company that wanted to import 45,000 gallons of the grog. Imagine the controversy today if Flinders Medical Centre negotiated a deal with Jack Daniels to build a new wing! Regrettably, it was soon affectionately known by the patients as the 'Sydney Slaughter House'. William was also accredited with introducing the 'new smallpox vaccination' to the colony, advocating for the improvement of hygiene on convict ships and marrying Surgery and Medicine into a more General Practice. To thank him, they named a suburb of Sydney after him and I suspect offered him a lifetime supply of 'grog'.

Others included D'Arcy Wentworth, a 'volunteer' acquitted of Highway Robbery but who was advised to leave the Old Dart anyway (he also worked on Norfolk Island for a time and helped to develop the Rum Hospital latterly), John White, the principal surgeon of the First Fleet, who investigated the use of Eucalyptus Oil for treating medical problems, and Arthur Bowes-Smyth who chronicled life on board the convict ships.

But these were not the first European 'Overseas Trained Doctors' to set foot in Australia and nor for that matter the first criminal doctors! That accolade lies with two others: the inconspicuous and melodic sounding Frans Jansz—a nice chap who was the surgeon on board the Dutch ship, Batavia, the pride of the Dutch East India Company—and the infamous Jeronimus Cornelisz who turned out not quite so nice. He started life in the Netherlands and settled as an Apothecary in Haarlem. He married and had a son who tragically died of syphilis less than 3 months of age. In his grief, he launched a legal action against the son's wet nurse blaming her for the child's demise which completely bankrupted him and so drove him to seek the riches that a role in the Dutch East India

Company offered. But mal-discontent on board the Batavia led him to plot a mutiny with the ship's skipper against the Commander, a merchant called Francisco Pelsaert. The ship was wrecked before they could launch their sedition and instead the mutineers, led by the disaffected 'GP', set about a vicious cycle of murder of up to 124 men, women, and children, including poor Frans, in a little over 2 months. Eventually he got his comeuppance and was captured by Pelsaert and the crew of a rescue ship. He was tried, had his hands hacked off with a hammer and chisel, and summarily hanged. Historians have suggested that he was indeed a psychopath, with ideas of setting up his own kingdom in the archipelago we know today as Houtman Abrolhos Islands off the coast of WA.

As the colony gained traction and as other colonies on the continent established themselves on the back of the discovery of gold, it seemed logical that more and more doctors were needed to service the growing population.

But let us also not forget the first true General Practitioners were not those transported or brought here as convicts or freemen. No, the first true General Practitioners were of course Aboriginal medicine men. Where the English regarded disease as being caused by miasmas (essentially bad smells from decaying matter, diseased parents, and sedentary habits) the Aboriginal medicine men took a far more holistic approach, choosing to communicate with the spirit of the sick person to make a diagnosis. Finding a spirit out of balance or even an evil spirit sent by an unscrupulous colleague was the first step in a healing response. Modern day GPs would regard this as psychosomatic disease. But that was fraught with some risk as it was believed that a person's spirit which essentially travelled through dreams and trances would go to an underworld. Consequently, these beliefs have like the culture endured the demands of time.

Aboriginal People to this day do not speak the name of a deceased person for fear of recalling their spirit. Sometimes they were more practical in their approach, insisting a sick person



had suffered some object or other stuck inside them such as a rock or a piece of wood. This would entail treatment with singing, massage, and sometimes even attempting to suck the offending items out of the hapless victim. As we are all aware, these medicine men had an impressive pharmacopoeia with which to treat various ailments. Here are just a few:

- Native hopbush (*Dodonea viscosa*). The leaves could be boiled and applied to treat earache.
- Arthritic joints were thrashed with stinging nettle (*Urtica dioica*).
- Lemon grass (*Cymbopogon* sp.) was used to treat fever and diarrhoea.
- Headache vine (*Clematis glycinoides*) was used to treat headaches by inhaling the aromatic oils from the crushed leaves.
- Corkwood tree (*Duboisia myoporoides*) was used as a narcotic for pain relief and as a poison for game.
- Kangaroo apple (*Solanum laciniatum*) was used to abort pregnancies or for contraception. Note, this plant was grown in the USSR, NZ, India, and Egypt to produce steroids used to manufacture the oral contraceptive pill.

Even today, Aboriginal Medicine practitioners can teach us much.

In comparison, the first European GPs had little to offer in the way of effective drugs other than maybe quinate, digitalis, mercury, strychnine, and opium, which if they didn't kill you probably resulted in some unusual effects. Of course, the Indigenous populations were decimated by European diseases such as smallpox to which they had no natural immunity and no effective medicines.

As the Colony grew, the needs of the many outweighed the aspirations of the few and the first General Practitioners were subsumed into the Colonial Medical Service on orders of the Governor, operating out of shabby tentage but doing a great job of keeping the great experiment on the road. The first colonists were 'bulk-billed', there was no private practice.

It is also worth noting to all of you aspiring doctors reading this that Australia's first apprentice doctor or 'medical student' was James Shears who apprenticed William Redfern. Born on Norfolk Island, he sadly died early on into his training aged 22 years and was duly replaced by the 14-year-old Henry Cowper. Not much is known about him except that when he eventually 'qualified' he was

often very, very drunk, ill-tempered, and generally demonstrated 'insane behaviour'. Does that remind you of anyone you know?

His career came to a crashing end in 1832 when he was dismissed by Governor Bourke for breaking into a female factory and supplying the convicts therein with Rum!

The years ground on and as the new world of Australia grew and thrived, more doctors arrived with their numbers swelling to an impressive 335 in NSW alone by 1864. Regulation and order set in and doctors formed themselves into self-regulating bodies, set standards, and ensured that doctors received adequate training and appropriate licensing.

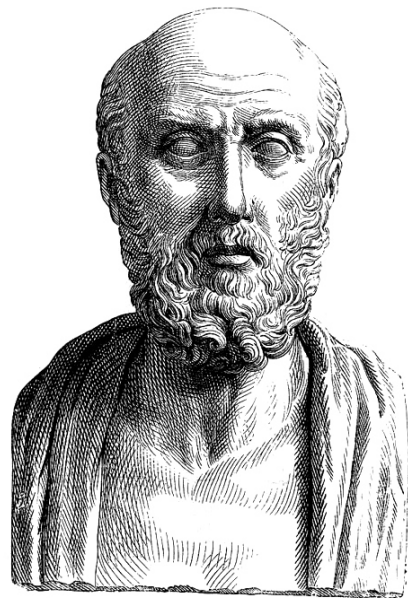
As a result, General Practice in Australia today, not unsurprisingly, is at the forefront in comparison with other health care systems around the world. There is so much unique history behind this, all of which has unfolded in such a short period of time. So as you sit down in your comfortable chair in your near future to ask Mrs Smith 'What can I do for you today....?', don't forget those who came before you; some were great, some not so great, and some were a bit naughty but they certainly contributed to the true history of General Practice in this great country.



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*If someone wishes for good health,  
one must first ask oneself  
if he is ready to do away  
with the reasons for his illness.  
Only then is it possible to help him.*

— HIPPOCRATES —





# FANTASTIC VOYAGE



## **ALICE DALRYMPLE** *MD2, Publications Director*

After a Reynaud's-tinged winter, Planet Earth is finally tilting toward tanning-is-skin-cells-in-trauma season. Tootsie-toasting meanderings along the beach and lashings of ice cream are just around the corner and you're beginning to contemplate your next getaway. Stop scrolling through those travel websites and forget about your aviophobia because Placebo's got you covered. The journey won't take long. In fact, you're already there.



## **Destination One: The Islets of Langerhans**

The islands making up this impressive archipelago are dispersed throughout the exocrine pancreas, a vast sea(-rous gland) of digestive enzymes that unfortunately prohibit snorkelling. Don't leave your Speedos at home though; the exquisite Mallory-Azan Hotel has three swimming pools to splash about in. The 60-suite establishment also boasts an impressive array of dining options and you're guaranteed to finish each day with one (or several) of the Beta Bar's famous insulin-stimulating concoctions.

## **Destination Two: The Sylvian Aqueduct**

For those of you who are fascinated by the Ancient World, the Sylvian Aqueduct is worthy of a few holiday snaps. No selfies here thank you. If you're willing to pay extra, Luschka and Magendie Tours offer private trips to the structure and you'll be able to collect a sample of the buoyancy-providing fluid as a souvenir.





### Destination Three: Substantia Gelatinosa

While Placebo—a reputed medical publication—doesn't condone comfort eating, we accept everyone occasionally needs a slab or two of cake to ease the pain of a long week. And there's no need to cheapen your adipocytes with shop-bought calories. Substantia Gelatinosa is famous for its decadent Black Forest Gateau, Apfelstrudel, and Sachertorte. Proprietor Luigi Rolando makes a mean cappuccino too. Someone pass me a fork!



### Destination Four: Las Thymus

If you're not the sort who prefers to snuggle up in front of a film come Friday evening, the bright lights of Las Thymus will keep you happy. Just hold onto your wallet. The glitzy casinos are frequented by Thymocytes—young gamblers with too much to spend and too little to lose. They'll differentiate into upstanding citizens eventually!

### Destination Five: The Grand Canal of Schlemm

If you're looking to cure your achy breaky myocardium on your travels, the Grand Canal of Schlemm might just be the drainage channel for you. This aqueous destination is all about romance so be sure to clamber aboard a gondola for some serious serenading. When the moon hits your photoreceptors with hyperpolarising light stimuli and you lapse into sinus tachycardia, that's amore! And if you and Mr or Miss Right feel peckish after your voyage, Limbus serves up some retinol-rich delights.





# A SLICE OF HISTORY ON UMBILICAL CORD CLAMPING

As most MDs learnt this semester, the cardiopulmonary transition from intra-uterine to extra-uterine life is both fascinating and incredible. During fetal life, the placenta functions as the organ of gas exchange, it oxygenates the blood vessels and supplies nutrients through the umbilical cord (from the maternal blood to the fetus). Soon after birth, the umbilical cord is clamped and the mother and newborn are separated.

This is one of the oldest medical procedures in history and one most of us share.

Following cord clamping, newborns no longer rely on the placenta, but are dependent on lung aeration and cardiovascular adaptation to achieve adequate oxygenation. Over the years, there has been controversy surrounding the timing of umbilical cord clamping. Clamping early (<60 seconds) or delaying (>60s) has been debated continuously, as our understanding of transition and the maternal and newborn benefits vs risks have developed and changed.

Variations in recommendations between organisations, hospitals and individuals exist due to emphasis on different research outcomes. However, with many scientific discoveries in the last decade, there has been a global major shift in one direction, driven by many organisations such as the World Health Organisation and International Liaison Committee on Resuscitation.

This shift has been towards delayed cord clamping by virtue of its numerous benefits - a recommendation that was also made much earlier in history by key physicians such as Aristotle, Hippocrates, Erasmus Darwin and Charles White.

So it seems the old thought is new again.

Why do we see the clamping, allows the the womb while still

Improvement cardiorespiratory increased blood volume and increased iron stores we have come a full we understand the hi practice, so we can e for infants, partic assistance at birth, a room

**Thomas Den**  
**1825**

"if the navel string is t child is born, even thou have been vigorous be will decline, it will nev breathing life or

**Hippocrates**  
**460BC - 370 BC**

Recognised the role of maternal blood and importance for nutrition

**Charles White**  
**1773**

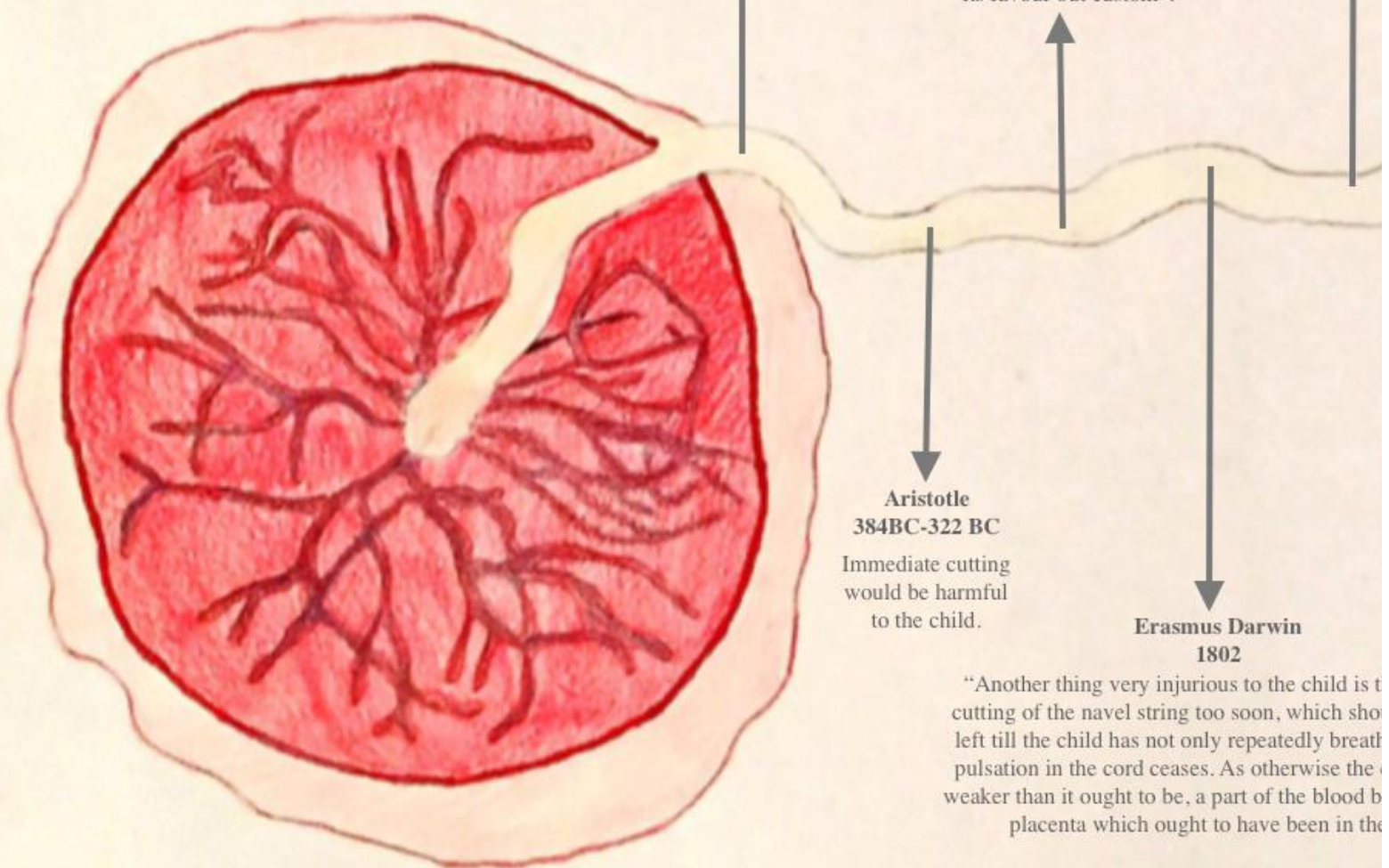
"[the] common method of tying and cutting the navel string in the instant the child is born... has nothing to plead in its favour but custom".

**Aristotle**  
**384BC-322 BC**

Immediate cutting would be harmful to the child.

**Erasmus Darwin**  
**1802**

"Another thing very injurious to the child is t cutting of the navel string too soon, which sho left till the child has not only repeatedly breath pulsation in the cord ceases. As otherwise the weaker than it ought to be, a part of the blood b placenta which ought to have been in the





# BILICAL CORD CLAMPING

Is this change now? Delayed cord clamping allows the newborn to adapt to life outside the womb while still being attached to its mother. Benefits have also been seen in preterm infants, including improved transition, and in term infants, including increased blood volume, decreased rates of anaemia, and increased iron stores by six months of age. As part of a full historical circle, it is imperative to understand the history of umbilical cord clamping to ensure a smooth transition to life outside the womb, particularly those who need extra support, and improve our future delivery room management.

enman

is tied the instant the baby is born, though the infant may not be able to breathe before, its condition will never acquire perfect form or it will die"

WHO, ILCOR, FIGO, RCOG, ARC  
2012 +  
Delayed Cord Clamping Guidelines

~1940

Rising fears of maternal-fetal antibody transfer causing erythroblastosis fetalis

Edward Maggenis  
1899

Invention of the midwifery surgical cord clamp - to be used upon cessation of the cord.

~1960

Rh(D) vaccine developed

is the tying and should always be left attached but till all the child is much better being left in the womb the child"

*"Our present is based on our past, and we should become fully aware of where we have been, and where we are, before we venture into the future"-  
John L. Thornton*

Pamela Gebrehivoot

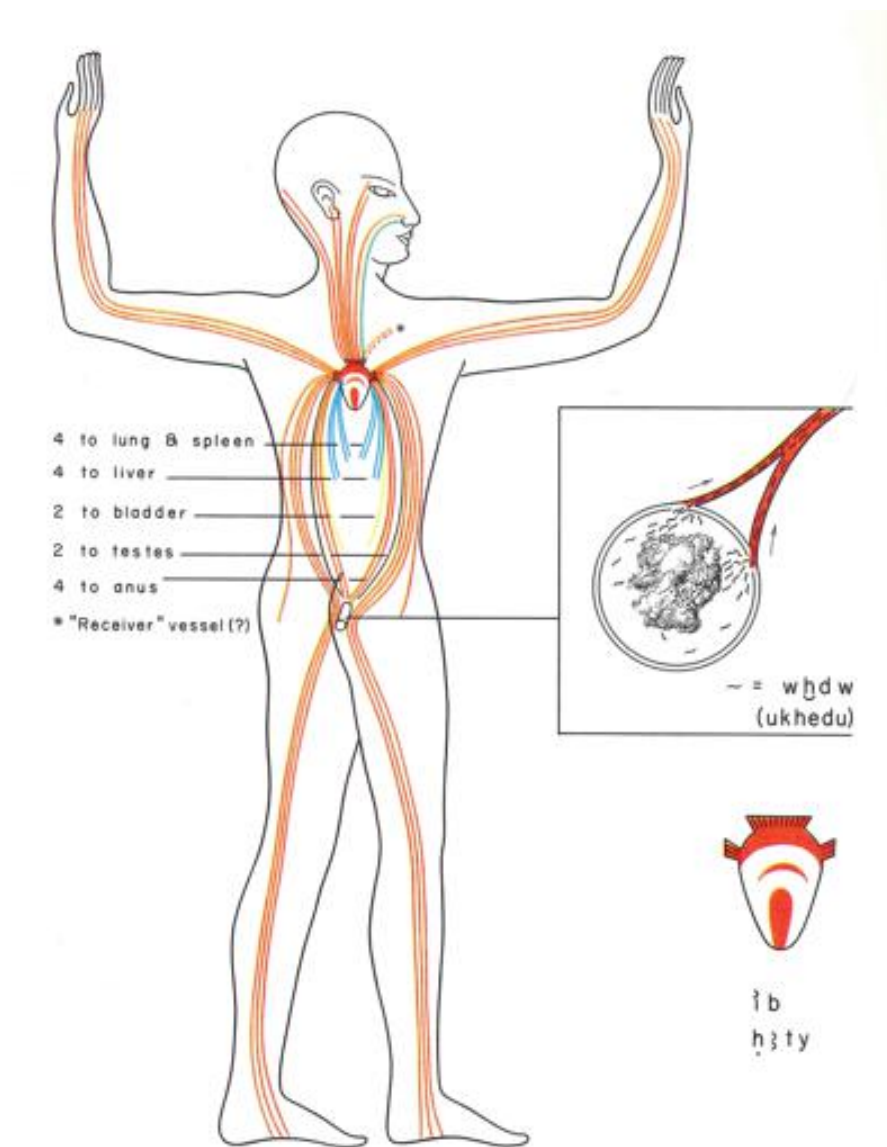
# ANCIENT EGYPT: Getting to the Bottom of Medicine

**KATIE CAMEROM**  
**MD1**

*Adapted from: Majno, G 1975, The Healing Hand: Man and Wound in the Ancient World, Second Printing, USA, pp. 69-149.*

Ancient Egypt was an oasis in the desert; the echoes of this glorious society have transcended antiquity and beyond. Its patients and physicians have long turned to dust, burnt by the unforgiving desert sun or entombed beneath the sand. Yet their stories have somehow found a way to us, future doctors in another millennium. Outlasting the pharaohs, some of the concepts within the Ancient Egyptians' practice of Medicine have intertwined with those of the Greeks and have been immortalised throughout history.

It's hard to imagine that this ancient civilisation spanned thousands of years and that in its beginning stone blades were the tool of choice. Hieroglyphs, for example, have been found describing a circumcision around 2250 BCE using a knife made from flint. Having said this, accurate translation of surviving hieroglyphs has been difficult and can be subject to interpretation. Stone ledgers have been found on which accidents were recorded by foremen to keep track of absentees on one of the Pharaoh's building sites. Entries include, "Fourth month of flood – day 27 – Nbnfr was ill – was stung by the scorpion" and, "On the first month of winter – day 21 – Tlmntw was absent – had a fight with his wife." That poor man Tlmntw must have been having a rough day; his predicament is described as knkn, which was also a word for the grinding up (using a mortar) of a drug into powder.



*The vascular system according to the Ancient Egyptians. All vessels came from the heart but they had a second assembly point around the anus. Some vessels carried blood (red) while others carried mucus (green), urine (yellow), semen (black), water, and air (blue). Air entered the nose, passed through the heart, and went to the anus.*

*Upper inset: A cross-section through the anus showing how the vessels opening into it could become flooded with excrement and transport the dangerous ukhedu.  
Lower inset: The heart could "speak" (? pulse) through the vessels.*

Ancient Egypt was a land of medical specialists: there were doctors for eyes, teeth, the belly, and even "hidden diseases" just to name a few. In particular, there seemed to be a great demand for "Shepherds of the Anus". No butts about it, the anus was the centre of the Ancient Egyptians' world and governed their daily life. Seen as the centre of decay for internal disease (because they understood that intestines were the same place where food decayed), this orifice was soothed, refreshed, smoked, and somehow

kept from "twisting" and "slipping". Ancient Egyptians were the all-time experts on enemas; they purged for 3 consecutive days in every month to get rid of the "evil" within. Faeces were believed to contain ukhedu, a spiritual type of rotting. Ukhedu was thought to lay dormant in the intestines but might arise pathologically to travel through vessels and settle anywhere in the body to wreak havoc. It could be male or female, could be "killed", and was responsible for wounds, disease, or pain.



However, the Ancient Egyptians did have an impressive understanding of the vascular system, concluding that the vessels (metw) flowed through a main centre within the heart. One inscription on a papyrus describes a physician placing hands or fingers “upon the head...upon the pulse, upon the two feet...[where] he measures... the heart.” Romantically, the heart was also thought to be the source of a person’s intelligence, personality, and emotion, which is why it was preserved in canopic jars whilst the unfortunate brain was scraped out through the nose and discarded during embalming.

There was a second point to be made to support the existence of vasculature, which of course originated from... the anus. Despite some knowledge of general anatomy from the practice of embalming, “vessels” were thought to contain blood, air, urine, tears, semen, or faeces depending on where they went. These vessels had “mouths” to take up drugs and would effectively “vomit out” the disease from under the threat of magic spells. Upon instruction of the heart they could jump, move, stretch, stiffen, tremble, or die within the body. Some vessels going down to the lower limbs passed so dangerously close to the anus that they were exposed to being “flooded with excrements” which could “rise up even to the heart”. Various remedies were said to strengthen, soothe, cool, or soften those rebellious vessels. Some scholars believe that the Egyptian concept of “bad blood” and getting rid of it was the basis for the practice of venesection, spilling millions of litres of innocent blood throughout the centuries that followed.

A peek into an Ancient Egyptian pharmacy would reveal all manner of herbs, spells, and ingredients. For example, willow leaves and dung were advised for drawing out inflammation

whereas red shepenn (possibly meaning red poppy, i.e. origin of opium) and sycamore leaves could be used for wound poultices. Similarly, grease was an important ingredient for wound care and could be made of anything from vegetable to snake oil. Myrrh was a famous expensive imported spice for healing and lint (a vegetable fibre) was used as a barrier contraceptive. Fresh meat, which may have worked as a mechanical plug or possibly aided with clotting factors, was used for bleeding wounds whilst powdered green pigment (copper ore) and salt were recommended for drying out a wound. Interestingly, green pigment was also applied as eye makeup and, due to the inherent antimicrobial properties of the copper compound, was probably useful in preventing eye infections. A “fail-safe” drink to placate a crying baby was red poppy extract with flyspecks scraped from the wall but honey was by far the most popular Egyptian drug, mentioned 500 times in 900 remedies. It came from wild bees and was practically harmless to the tissues as well as being aseptic and antibiotic. It was also often coupled with a charm upon application, such as, “I prepare him honey which is sweet to men, but bitter to the dead.” Magic was a perfectly logical therapy; an accepted science with Isis as patroness that was administered in combination with medicine depending on the ailment.

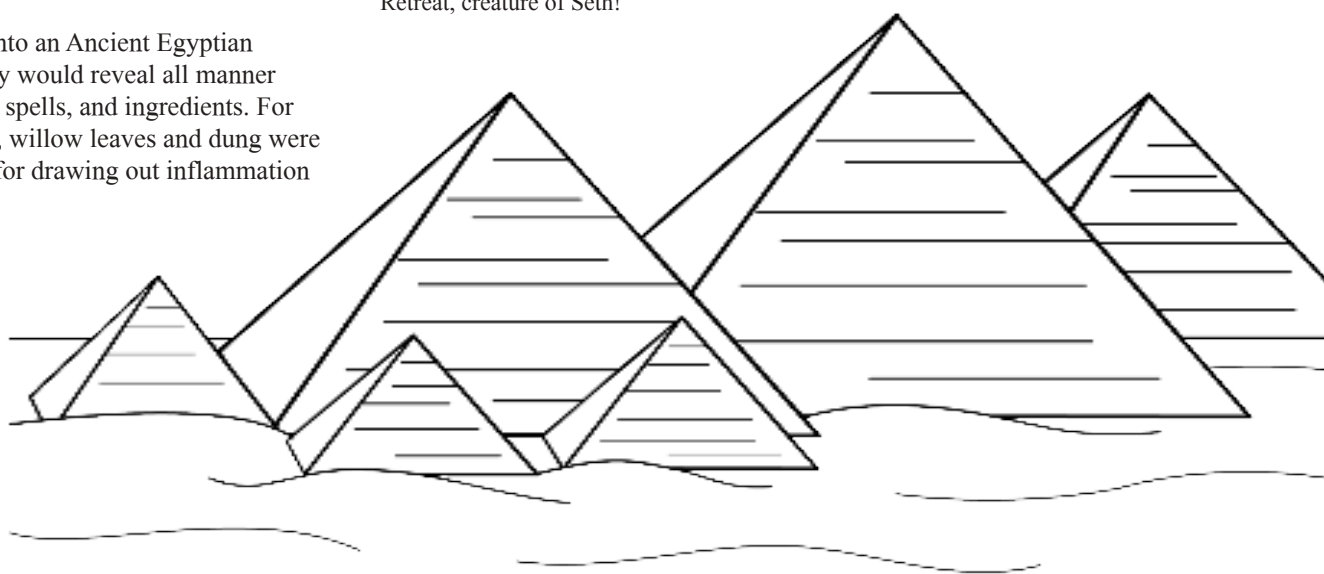
This charm to “dispel blood” (possibly meaning to stop bleeding/redness) would be recited over a red cornelian gemstone placed in the anus (obviously) of the sick man or woman:

Retreat, creature of Horus!  
Retreat, creature of Seth!

Dispelled be the blood that cometh by  
Wnw [a city]  
Dispelled by the red blood that cometh by  
wnw [by the hour]  
You know not the dam, retreat before  
Thoth!

According to the Smith papyrus, Ancient Egyptian healthcare could be categorised by physicians into three main classes. “An ailment which I will treat” was seen as having a good chance of success, e.g. a penetrating wound could be held together with adhesive strips made from gum/resin (the use of stitches was unlikely on live patients but embalming sutures have been found on mummies). “An ailment with which I will contend” meant that the doctor would treat as he could and then wait for nature to decide whether the patient lived or died, as in the case of overriding infection or disease. Finally, a case of “an ailment not to be treated” might be feeling a cancerous lump: “if thy puttest thy hand upon his breast upon these tumours, and thou findest them very cool, there being no fever therein when thy hand touches him...and they are bulging to thy hand...there is no treatment.”

Although some of these remedies seem silly given our current scientific understanding of symptoms and diseases, the Egyptian medics were renowned across the ancient world for their expertise and provision of medical treatment. Armed with logic in their quest for medical knowledge and their mastery of astronomy, geometry, and engineering, they unlocked many secrets of our universe, some of which remain for us to find and others will never be known to us.



# Flying into the Future of Rural Health

**MATILDA SMALE**  
**MD1, Publications Officer**

How often do we see a \$20 note without thinking of the amazing work for healthcare in Australia that led to Reverend John Flynn's face being there? The unique rural and remote areas of Australia have posed many challenges to healthcare and continue to do so. The Royal Flying Doctor Service (RFDS) is one example of how these challenges can be viewed as an opportunity to improve the services we provide to some of the most isolated areas of this country.

In 1911 Flynn witnessed the struggles of individuals living in remote areas of Australia and this created his vision to provide a "mantle of safety" for these people. 17 years later, with the assistance of H. V. McKay, Flynn opened the Australian Inland Mission Aerial Medical Service in Cloncurry, Queensland and the now RFDS departed on its first flight. Fastforward 89 years to 2017 and the RFDS has a fleet of 66 aircraft operating from 23 bases across Australia. This enables the service to provide 24/7 medical care across 7.3 million square kilometres, with pilots flying distances totaling 34 round trips to the moon annually.

Through the Ride Along Program, Flinders University medical and nursing students can experience first-hand the work the RFDS does. This program is supported by the Rural Doctors Association of Australia (RDAA) and the Flinders University Rural Health Society (FURHS).

Ilze Alexander (MD 2) was fortunate to participate in the program:  
*"It was amazing to see different emergency teams around the state working together in such a coordinated manner to get critical care to these patients. Each transfer included the hometown medical team, two ambulance crews, the RFDS crew, and the medical team at the Adelaide hospital that the patients were transferred to. Every patient we picked up was so grateful for the care they received...care that we take completely for granted living in a metropolitan centre. Going along for the ride allowed me to see first-hand the crucial part the RFDS plays in providing medical care to rural and remote communities and reminded me why I am so passionate about rural health in South Australia."*



*Medical cabinet carried on aircraft in 1958 on display in the Royal Flying Doctor Museum in Alice Springs.*



*Medications carried in 2017; how times have changed!*





*Michael at the RFDS base in Adelaide.*



*Sarah flying over the South Australian coast.*



*Photos taken by Michael Robb (MD 1) and Sarah McArthur (MD 1) on the Ride Along Program and by Matilda Smale (MD 1) at the Royal Flying Doctor Museum in Alice Springs.*

*The interior of an RFDS plane; truly amazing what they can fit in such a small area!*



Nathan Lang (MD 1) reflected on his day with the RFDS:  
*"The plane is basically a mobile ICU/ Emergency Department so it was great to see how much technology and equipment they can jam into the plane and to see what the most valuable pieces of equipment were. The patients that we picked up had cardiovascular-related problems and given that we had just finished the cardiovascular block it was interesting to see the theory applied to practice."*



# A Peek Inside the New Royal Adelaide Hospital

**MATILDA SMALE**

**MD1, Publications Officer**

**HARITI SALUJA**

**MD1, Marketing Officer**

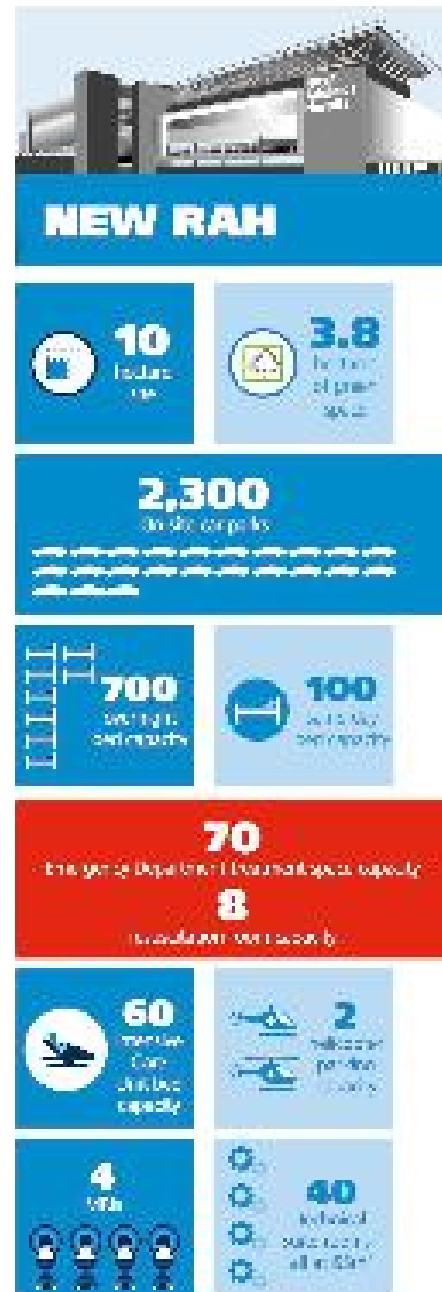
The Royal Adelaide Hospital first opened on North Terrace in 1840, many years prior to the opening of Flinders Medical Centre and the Queen Elizabeth Hospital. This central Adelaide hospital has provided care for multiple years, with the Emergency Department alone servicing 73,000 patients annually. The 650 beds have provided comfort and support to many patients over the years and have witnessed the delivery of bad news and moments of joy. As history has shown us, all good things must be upgraded to support the growing needs of the community. As a result, the long-awaited new Royal Adelaide Hospital (nRAH) is opening its doors officially on September 6th 2017, ready to kick start some key changes in Transforming Health.

Hariti and I were fortunate enough to attend a tour of the nRAH with other members of the public. We were told by our eager tour guide that the move

of a hospital is thought to only happen once every 200 years so this was a once in a lifetime opportunity. As we walked through the doors of one of the most expensive buildings in the world, we were amazed at the architecture highlighting open spaces and natural light. Our amazement continued as we progressed into patient areas and were informed of minor changes which focused on patient care and infection control. Each of the 800 single rooms will contain a day bed ready for a family member to stay at any time and small windows allow health professionals to observe the patient and minimise interruptions. The ward walls are decorated in South Australian artwork and photography, which brings a contemporary style to the hospital.

Continuing to the ICU we are told the windows have been lowered by 30 centimetres which will allow for a patient to see outside when lying down in the bed. Empty rooms in the ICU which overlook the beautiful court yards ignited our curiosity and we were told that once stable, patients can be brought here in their beds. It appears that the nRAH has implemented small changes which are anticipated to have a large impact on improving patient care. Further to this, separate elevators for health professionals and shared workspaces for interprofessional teams are aiming to improve the efficiency of the care delivered.

The nRAH is built for success, with aims to improve patient care and experience in the hospital.



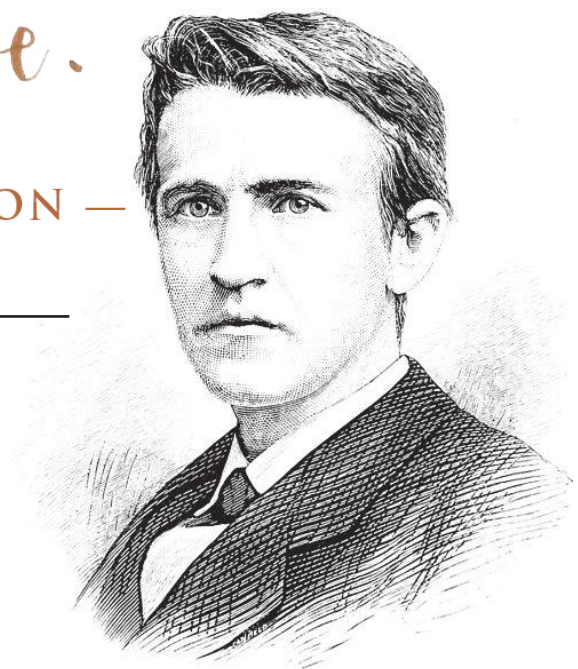




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The doctor of the future  
will give no medicine,  
but will interest his  
patients in the care of  
the human frame,  
in diet and in the  
cause and prevention  
of disease.

— THOMAS EDISON —





## OPINION



### How About A Cup of Tea?

**ALICE DALRYMPLE**  
*MD2, Publications Director*

Mr Jennings was proud of himself. He lived in a nice house in a nice street with a nice wife and two nice children. He drove a nice car. He had a nice job. And he knew everything...or at least anything worth knowing. He knew Mrs Jennings liked a cup of tea in bed every morning but he didn't know where the tealeaves in the teabag came from. He knew Billy Jennings would only eat his carrots if they were smothered in ketchup but he didn't know how ketchup was made. And he knew when he woke up one Thursday morning in July with a throbbing headache, a fizzing nose, and a sandpaper throat that he needed antibiotics. It was time to see a doctor.

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The waiting room was as stuffed as Mr Jennings' head. Mothers with red noses clutched at toddlers with red faces, pensioners held their belongings to their crackling chests and muttered about parenting, and receptionists periodically periscoped cans of disinfectant room spray above the desk.

Mr Jennings watched as a dishevelled doctor scuttled into the waiting room, squeaked his patient's name above the clamour, and retreated to his office before anyone could shout anything about how long they had been sitting there for. It was pandemonium. It was winter. All Mr Jennings needed was a prescription and he'd be on his way.

"Mr Jennings to see Dr Thyme at 10 o'clock please," he said to a pink-haired, nose-studded girl behind the desk.

"Take a seat," she replied, "shouldn't be long."

She was right. Mr Jennings had barely read the headline on the front page of his newspaper before a sing-song voice called his name. Dr Thyme wasn't like any doctor Mr Jennings had seen before. She was too young for one thing. And her hair! Surely that mane was an infection risk? Her office was even more unusual. Her desk sagged under the weight of crusty, dusty anatomy tomes and the shelves above the examination table were lined with what Mr Jennings assumed were old surgical instruments.

"What can I do for you today Mr Jennings?"

"Hmmm...", he tore his eyes away from the crumbling bundle of dried

herbs on top of the cupboard, "oh, I just need antibiotics."

"And why do you need antibiotics Mr Jennings?"

He wasn't sure how to answer. Weren't doctors supposed to give him what he wanted?

"Well, I've picked up a cold and two or three tablets always make me feel better."

"No."

"I beg your pardon?"

"A cold is a virus Mr Jennings. Antibiotics are used against bacteria."

"Other doctors give them to me."

"Perhaps other doctors aren't as concerned about antibiotic resistance as I am. Mr Jennings, you should be tucked up in bed with a hot dri..."

"Maybe you should go back to medical school. If you don't write me a prescription, I'll go and see another doctor."

Her blue eyes flashed and a wicked smile crept across her face.

"I'm sorry for using your time Mr Jennings," she said as she twisted the





## OPINION

end of her stethoscope three times.

“Have a nice a day.”

\*\*\*

Mr Jennings yanked open the door and stepped not into the hallway with its peeling linoleum floor but a courtyard dappled by gnarly olive trees. He rubbed his eyes. He was hallucinating. He had offended Dr Thyme so much that she'd slipped him some substance on his way out. When he looked again, the courtyard was as real as his headache. He felt behind his back for the door handle but it had vanished into hot, honey-scented air. He didn't know where he was and he didn't know what to do.

“You look lost.”

Mr Jennings turned to see a sun-dried man steadily desiccating on a stone bench beneath one of the olive trees. The top of his head was bald but his thick white beard curled its way down his bony chest. His eyes were almond-shaped and gazed down his aquiline nose at Mr Jennings.

“Yes... Um... Can you please tell me where I am?”

“You're on Kos my dear fellow. But how could you not know that?”

“Sorry... Um... Not feeling my usual self.”

“You've stumbled into the right courtyard then! My name is Hippocrates and I am a physician. What can I do for you today?”

Mr Jennings hadn't heard of Kos or Hippocrates.

“I just need a prescription for some antibiotics.”

“A prescription for what? In my learned opinion, what you really need is some bodily humor tweaking. Tad too much phlegm.”

Mr Jennings had heard of phlegm. He was producing a lot of it. Perhaps this Hippocrates knew what he was doing after all.

“My serum will get you back to your

self in a jiffy.”

Hippocrates handed Mr Jennings a bowl of cloudy white liquid. It smelled like the cheese box at the back of his fridge. He took a sip.

“Eugh! That's disgusting,” cried Mr Jennings as the serum sloshed onto the sandstone. “It's just sour milk. You some kind of quack?”

“It's whey actually. And you've just wasted a good amount of it.”

And with that, Hippocrates shuffled his sandals out of the courtyard.

First Dr Thyme, now Hippocrates. Where did these doctors train? Mr Jennings made to follow Hippocrates but as he raised his right foot the courtyard dissolved into a sodden forest.

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Mr Jennings again rubbed his eyes but raindrops continued to pommel his shoulders and moss continued to squelch beneath his feet. Hippocrates' serum must have disagreed with him.

“Next!”

The voice had come from a rickety wagon wedged between two enormous fir trees. As Mr Jennings took a tentative step forward, a kyphosed woman appeared in the doorway and began to gingerly unfold her crooked, creaking limbs down the steps.

She shot Mr Jennings a toothless grin as she hobbled past and wheezed, “he's a miracle worker that Ulric. Yanked out my tooth without me feeling a thing.”

The celebrated Ulric emerged from the wagon too. Mr Jennings thought he looked more like a butcher than a doctor. His filthy apron was spattered with what could only be blood and his stubby nails were caked with grime.

“Oi,” he shouted at Mr Jennings, “don't keep me waiting.”

Mr Jennings swallowed hard. It was worth a try.

“What d'you need?”

“You're the third doctor I've seen today. I feel terrible and my head's killing me. I just want some antibiotics.”

Ulric sucked all five of his teeth.

“Never heard of those. Some new-fangled thing in your neck of the woods are they? Come inside and I'll see what I can do.”

If Mr Jennings was unsettled by Ulric's physical appearance, he was utterly repulsed by the state of the wagon. Blood-soaked rags festered in the corners and horrific instruments hung from hooks skewered into the roof. Ulric flicked a glob of something hopefully non-human off the workbench and proceeded to pick at an oozing spot on his chin.

“Take a seat and roll up your sleeve,” he said as he plopped several somethings into a bowl. “These little blighters will help to begin with.”

Mr Jennings could now see what the little blighters were: leeches bulbous with blood.

“Bit lethargic I'm afraid. Been using em' all morning. And if your head's really killing you, I'll have to drill a small hole above your nose to let out the demon you've picked up.”

Leeches? Holes? Demons? Mr Jennings dived through the door and tumbled not into the forest but onto a Nightingale ward teeming with starched nurses and spectacled doctors. This was more like it.

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Mr Jennings sidled up to the man he assumed was in charge. He had a strong jaw, thick eyebrows, and efficient hair and had his inquisitive eyes fixed on the whimpering bundle of bones in the bed before him. Mr Jennings glanced at the papers in the doctor's hands, focusing almost instinctively on a very welcome word: penicillin.

“I need that,” cried Mr Jennings.

“Excuse me?”

“Penicillin. It'll make me better.”



## OPINION

"With any luck Sir, it will make a lot of people better."

"Could you write me a prescription then? A few doses should do it."

"I'm sorry, but this poor gentleman has just received the last vial. It's enough trouble producing penicillin for one person let alone countless others like yourself. We've been extracting it from his urine..."

"Telephone call for you Dr Florey," interrupted one of the nurses.

"If you'll excuse me."

Mr Jennings was very confused. Since when had there been a shortage of penicillin? What had Dr Thyme said? Something about resistance? Was this that? He was about to shout after Dr Florey but a tower of clean bedpans stumbled into him and the ward went black.

\*\*\*

"Code Red! I repeat, Code Red! Someone get the decontamination team down here now! Over."

Mr Jennings was steadily regaining consciousness. A static response jerked its way down his ear canals.

"He's not wearing a microbe defense suit? Over."

"Jeez Marshall, I said Code Red didn't I? We need to disinfect him ASAP. The G.E.R.M. console is detecting a centuries old rhinovirus. It may be too late to save him but we need to protect the colony. Over."

"Sorry Warren. Team dispatched. Stay safe. Over."

Mr Jennings was fully awake now. He was lying flat on his back in a most peculiar room. The steel floor didn't extend to the walls. Rather, the platform was floating in the centre of a glass cylinder. It was dark outside. Mr Jennings could see stars. He'd be late home for supper.

He clambered to his aching feet.

"Stay back," shouted Warren. "One more step and I'll stun you."

Mr Jennings could now see that Warren was cocooned in a yellow spacesuit. Behind the green-tinted visor he was pale and scrawny and blotchy with itchy looking welts.

"I can't help it if I'm allergic to water."

Warren was evidently self-conscious about his complexion.

"Where am I and what on earth are you wearing?"

"Did you say Earth? Oh jeez, you hijacked the transporter system didn't you? General I. M. Munity said this would happen. Bet you thought no one would notice if you beamed yourself onto the Salubrion. Bet you thought we'd just take you in."

"Transporter system? Salubrion? Look mate, I just want some ruddy antibiotics!"

Instead of responding to Mr Jennings, Warren fumbled for his walky-talky.

"Marshall, he's aggressive and he's delirious. He wants antibiotics. I need an ETA on the decontamination team. Over."

"60 seconds. Keep him talking. Over."

"Earth lost antibiotics 400 years ago. Do you think we have some aboard the Salubrion? Is that why you hijacked the transporter system?"

"Don't give me any of that rubbish. And I didn't hijack anything. First Dr Thyme, now you. I'm sick and tired of being fob..."

"Dr Thyme sent you here?"

"I'm starting to think she did... Do you know her?"

"I do. You better follow me. Just keep your filthy hands to yourself."

Warren once again reached for his walky-talky.

"Marshall, reroute the decontamination team to the EDU bay. He's with Dr Thyme. Over."

"Take a seat."

As Mr Jennings made himself comfortable, Dr Thyme's hologram rose out of the floor. She was wearing a silver body suit but still had her stethoscope draped around her neck. She clicked her fingers and Mr Jennings was back in the waiting room, or at least a simulation of it.

"Earth 2017," Dr Thyme's hologram said, "inappropriate prescribing of antibiotics is hastening resistance."

The simulation changed to a crowded Emergency Department.

"Earth 2077. Antimicrobial resistance kills more people than pandemic influenza."

"Enough," cried Mr Jennings. "I want to go home."

\*\*\*

The shrill beeping of the alarm clock disturbed the warm doziness of Mr and Mrs Jennings' bedroom. It was Thursday. Mr Jennings groaned as Mrs Jennings stretched and reached for her glasses. He felt terrible. He had a throbbing headache, a fizzing nose, and a sandpaper throat.

"Maybe you should go and see a doctor Love," yawned Mrs Jennings.

"No," he said, "it's just a virus. I'll tell the office I'm not coming in today. How about a cup of tea?"



## FEATURED NAMES

**Jennings**

Margaret Augusta Jennings was a British scientist who worked with and later married Lord Howard Walter Florey. Girl power!

**Dr Florey**

Australian pharmacologist and pathologist Lord Howard Walter Florey studied Medicine at the University of Adelaide; his bust adorns North Terrace. He was awarded the Nobel Prize in Physiology or Medicine in 1945 with Sir Ernst Boris Chain and Sir Alexander Fleming for developing penicillin.

**Marshall and Warren**

Australian physicians Professor Barry Marshall and Professor Robin Warren were awarded the Nobel Prize in Physiology or Medicine in 2005 for discovering *Helicobacter pylori* and its role in gastritis and peptic ulcer disease (PUD).

# Question from Darwin

*A new series introducing our Northern cousins.*

**Name:** Jean Pepperill.

**Age:** 29.

**Year group:** MD 2 (Class of 2019).

**Before medicine:** When I left school, I wanted to be an Egyptologist so I studied a Bachelor of Arts at Macquarie University. Halfway through I realised I didn't want to be an Archaeologist for the rest of my life. I didn't know what to do so I worked in the Aboriginal art industry in Alice Springs for a few years which is where I became interested in Medicine. I did a Bachelor of Science at Griffith University as a pathway into Medicine.

**What I like best about studying in the NT:**

The people. My cohort get along really well and we all support each other.

**What I do in my spare time:** Read and write, stargaze, learn French, and quilt.

**Fun fact:** I'm a Kaytetye woman from Barrow Creek in the NT.

**Dream job if I wasn't studying Medicine:**

Cosmology or Astrophysics.



## Help raise \$50,000 to buy new brain monitoring equipment

**Your help is urgently needed** to buy new seizure monitoring equipment to **help thousands of people** with epilepsy across Adelaide to become “seizure-free”.

When anti-convulsant medications don't stop people with epilepsy from experiencing seizures, often the last resort is a week-long stay in Flinders Medical Centre's (FMC) seizure monitoring room.

Here, patients are connected to an Electroencephalogram (EEG) machine (pictured), with electrodes attached to the head to monitor brainwave activity 24-hours-a-day, while specialists seek to pinpoint the source of seizures.



By raising \$50,000, a new EEG machine with the latest software and video monitoring equipment can be purchased for the seizure monitoring room to **help doctors more accurately diagnose people with epilepsy** and suspected-epilepsy, and get them the answers they are desperately seeking.

“When someone is having regular seizures, they can't drive and often they can't work because **they just don't know when their next seizure will be**, so they're quite disabled,” FMC Neurologist Dr Joe Frasca says.

“If patients aren't responding to different types of anti-convulsant medications then we need to explore every other option for them to become seizure-free.

“By using seizure monitoring equipment like EEG, we can study where seizures are occurring in the brain to see if we can localise it, and potentially operate on that area.

“Becoming seizure-free is life-changing, and **with access to the latest technology we will be able to more accurately diagnose epilepsy and make a real difference in more people's lives.**”

You can **help bring this vital equipment** to the Neurology Service at Flinders Medical Centre, so thousands of people living with epilepsy across Adelaide can be more accurately diagnosed.

Your generous donation will **help make this possible.**





**Your gift today will help buy a new EEG machine which is urgently needed, so thousands of people with epilepsy across Adelaide can stop having seizures.**

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## Thank you

Your privacy is important to us. Your personal information will be collected, used and disclosed in accordance with our privacy policy. This can be viewed on our website or by contacting us. Any additional funds raised will be used to support the research and care provided to patients by the Southern Adelaide Local Health Network Neurology Service. We value your support and would like to keep you informed of the difference you are making. If you would prefer not to receive similar mailed communications, please call (08) 8204 5216.

# SOCIETIES



## GPSN Cultural Immersion Camp

The Kakadu cultural immersion trip was a brilliant experience and a really interesting way to learn more about Indigenous culture and healthcare in Northern Territory communities. I found the experience added greatly to my understanding of how medical services are provided in government facilities such as the Jabiru Health Clinic and in community-based clinics such as Oenpelli. It was also wonderful insight to travel to culturally rich landscapes and traditional lands that hold the stories and history of a long ancestry. To see the paintings and hear the beliefs of people about family, life, and healing was very interesting to be a part of. I felt very immersed into the culture and intricate family relations of the generations of Bininj/

Mungguy that have lived on and cared for this country for tens of thousands of years. Sharing and looking after country have always been a part of the Kakadu story. The spiritual connection of Kakadu's Aboriginal people with the land is globally recognised in Kakadu's World Heritage listing, which honours one of the oldest continuing societies on Earth. It was an authentic camping experience just 70km downstream of the world-famous Jim Jim Falls. I would highly recommend this Kakadu cultural immersion camp by GPSN to all who can come along! The camp facilitators, GPs, and other medical students who shared the experience were all brilliant and brought diverse understandings to discussions about the beauty and challenges of providing healthcare in remote settings in the Northern Territory.

***Nirali Patel, MD1***

\*\*\*

I was fortunate to be given the opportunity to attend the cultural immersion trip to Kakadu organised by GPSN and Northern Territory

General Practice Education (NTGPE). We stayed with the Murumburr clan at the Kakadu Billabong Safari Camp; they taught us much about their culture. We learnt about their kinship systems and were given skin names which welcomed us into the group and determined our relationships to each other and our interactions within the camp.

We shared stories around the campfire, learnt to dye and weave pandanus into bracelets, saw and listened to stories about ancient rock art, and got to sample bush foods such as wild honey and fruit bat! We saw crocs and brumbies and visited a beautiful art gallery in Gunbalanya as well as a few Aboriginal Health Clinics. The weekend provided great insight into the rich culture, knowledge, and context of Aboriginal people living in remote communities which will stay with me for life. I feel extremely privileged to have had the chance to attend the camp and cannot recommend it enough to people in future years!

***Casey Welsh, MD3***



## SOCIETIES



Rock art in Gunbalanya



Gunbalanya.



Dyeing pandanus.



Croc hunting.



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And remember:  
you must never,  
under any circumstances,  
despair.  
To hope and to act,  
these are our duties  
in misfortune.

— BORIS PASTERNAK, DOCTOR ZHIVAGO —





# NOT a Review of MedRevue

**JAMES COHEN**

*MD2, MedRevue Director & Co-Writer*

By way of introduction I should make a small disclaimer. I was somewhat involved in this year's MedRevue, The Little Intern. This means much of what I say comes from the biased position of a writer/director. While it is tempting to write your own reviews, I will refrain from doing so. If you want to know if the show is good or not, ask someone who came to see it. Over 500 people purchased tickets across the two shows, some even saw the show twice, so there are plenty of would be reviewers you could ask in my stead. If you were unfortunate enough to be ill or incapacitated on both nights, I will briefly tell you about our show. Then, rather than critiquing the show here, I would like to tell you a little bit about MedRevue; what it is, how and why we did it, and why you should get involved next year.

MedRevue re-emerged from a long hiatus in 2016 with Aladdin: Prince of Paeds. Again, sadly I shouldn't comment on the quality of this show because I was in it. I'm told it was good. It was the first time that med

students had been on stage together since an ill-fated production of The Flinders Power Rangers. What went on in that show is uncertain but it saw the end of MedRevue for a long while. This year's production of The Little Intern saw ever greater involvement from a larger cast and crew. Talented students from fresh faced Clin Sci year ones all the way up to an overworked fourth year student took to the stage to tell the story of Ariel Fish. Ariel faced all the normal challenges of a medical student and rose to them with passion and excitement until the day she was torn away from the big city hospital she loved and sent to the "one light" town of Mount Gambier. Unlike her oceanic counterpart, Ariel never longed for a sea change to be with her love at first sight but rather to be in the hospital which would afford her the greatest career advantage. Through the show, she sees the important role that rural GPs play in a small community and how perhaps city practice might not be what she wants for her medical career after all. The show's final message was one of open-mindedness towards the future. Shy characters grew confident, those that seemed crazy were right all along, and of course the bad guys got what was coming to them.

MedRevue has already grown so much in its 2-year return. We hope that it will continue to grow both in student involvement and ambition because we are uniquely positioned to tell stories. Med students are intrinsically creative. It is this creativity that drives our fascination with anatomy and

biology. This artistic flair that allows us to discover and forge connections between information and come up with all those acronyms. This also allows us to tap into the human side of Medicine. There are many medical stories for Flinders MedRevue to tell. Stories of struggling with long work hours and eventual rewards, stories of library shelf romance, even stories of dealing with loss and failure. I hope that as MedRevue grows we can share more widely what it is like studying and working in Medicine, to both inform and entertain.

To continue to grow, we hope to see many more people becoming involved. There are so many reasons and ways to do so. MedRevue provides an opportunity to once again "tread the boards" for those for whom theatre has always been a passion. It can be a creative outlet after a long day sitting reading medical textbooks. It can allow you to take off the mantle of medical student and for an hour or two be a completely different character. It builds confidence making those standardised patient interviews just another theatrical performance to be rehearsed and mastered. MedRevue also affords an opportunity to meet med students from all year levels, forging friendships that otherwise may have gone unformed, becoming part of a MedRevue family. At The Little Intern after party, my mind hazy from celebratory punch, one cast member from this year's show related to me how much they had grown in confidence throughout the show



and how they felt more prepared for their med school journey. This was perhaps the most meaningful feedback I received about the show, it brought a tear to my eye.

If perhaps being onstage is not your thing I would suggest, after first suggesting that you give it a go anyway, that a production role might be more your style. This year we had an amazing team working on costumes, some of them sewn from scratch. This in addition to an amazing set and props crew with one of the slickest backstage crews I have ever worked with. So, if it is not the lights and applause you're after, maybe you'd look good in theatre blacks! MedRevue will always have a job for anyone who wants to be involved.

Finally, perhaps you would prefer to write the thing. This can be rewarding, or difficult. I was lucky enough to have three supportive and talented co-writers and two lyrical geniuses to help me, because you do not want to do this alone. One of the co-writers expressed to me how hearing their own words performed on stage sent a chill up their spine, and I can relate. It has to be one of the most satisfying experiences of my life, you really should try it.

I would, at this point, like to again thank everyone who came to see the show and all of those involved. It was a blast. We hope to see YOU next year!





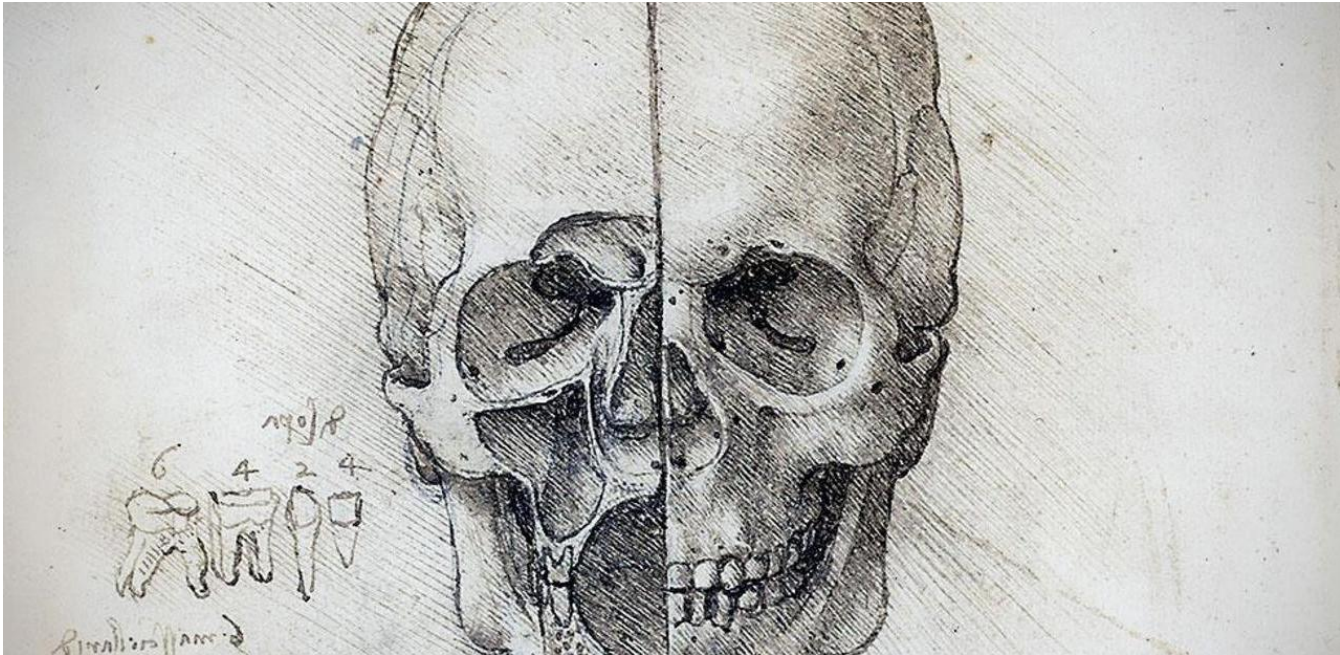
## SOCIAL





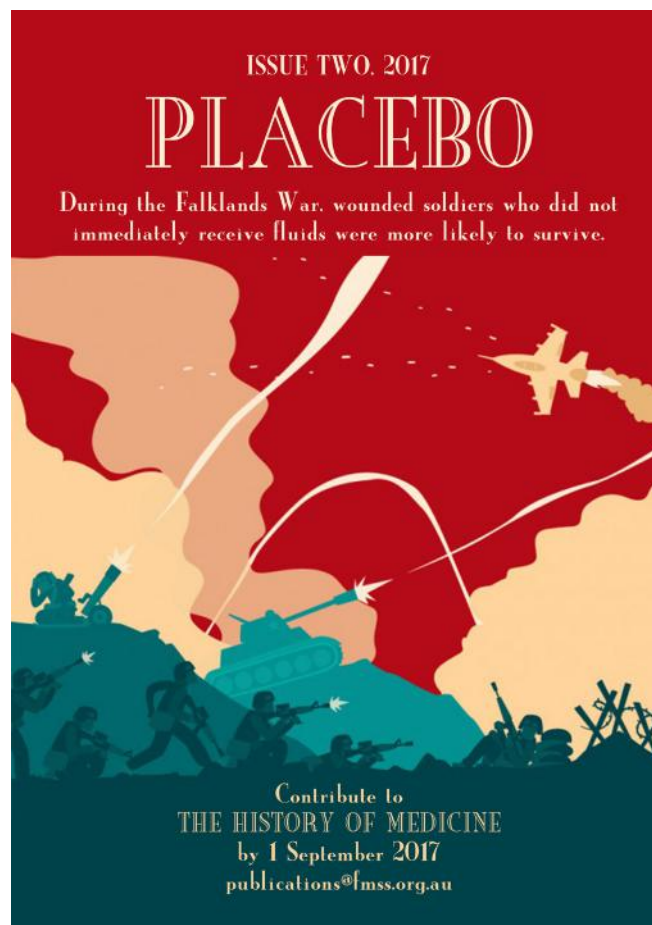
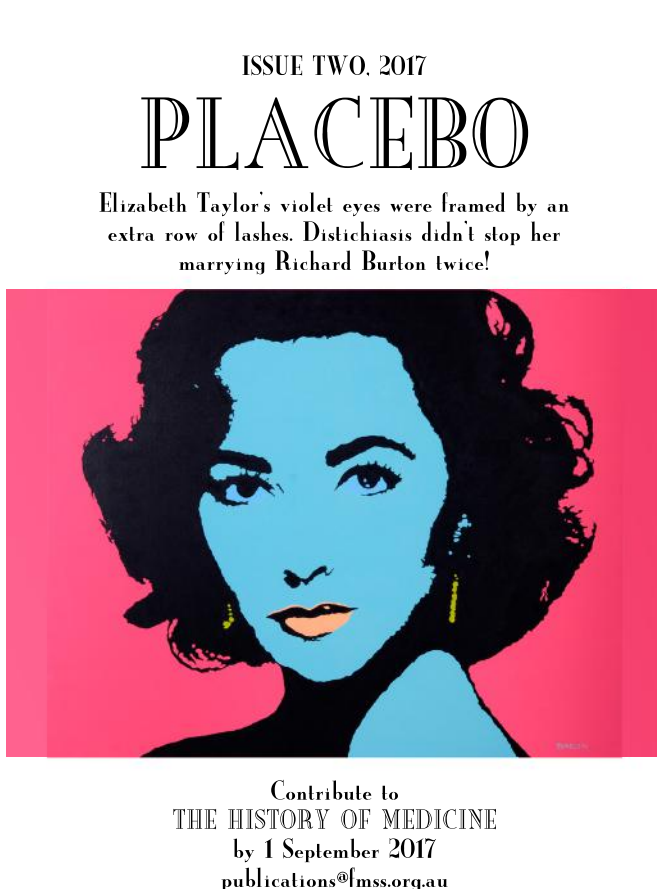
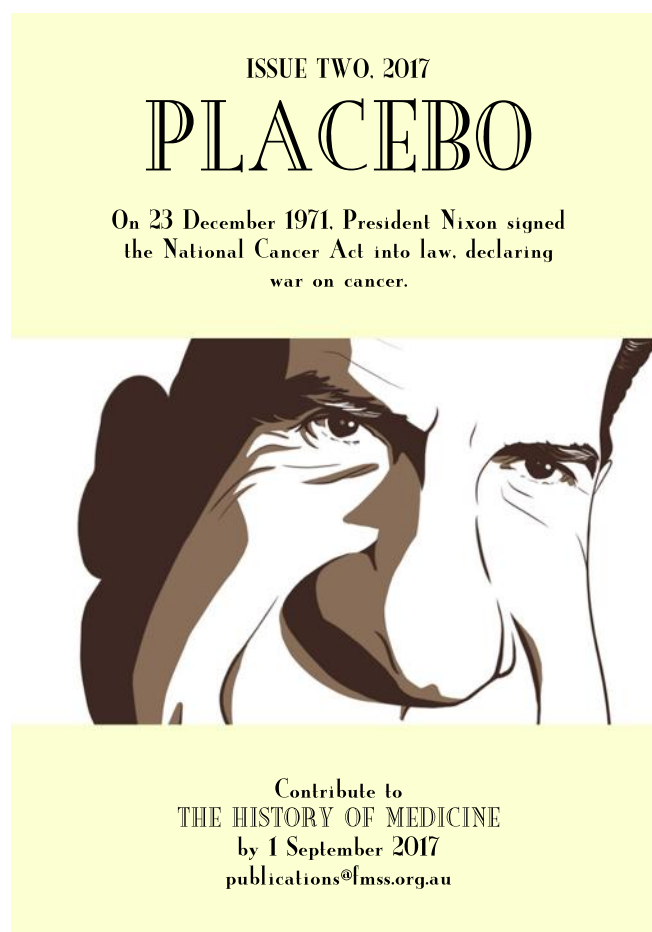
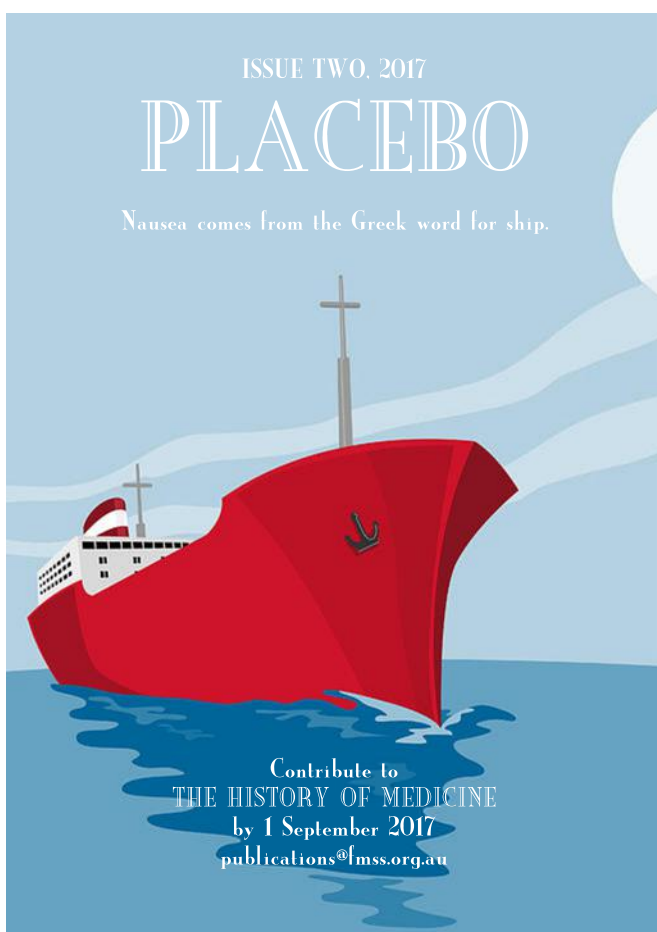


# PLACEBO 2018



**MATILDA SMALE**  
*Publications Director 2018*

Placebo will be back in 2018 with two issues throughout the year. The Placebo team is excited to reveal that Issue One will be themed Influential Figures in Medicine. We will be asking for Issue One submissions by the end of March, so use your holiday break to entertain your creative side. Submissions can be anything from a short story, a reflection on an experience or an interview, to poems and drawings. Please send your submissions to:  
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