Issue 4: Volunteering & Electives November 2015

The Pulse

Newsletter of the Deakin Medical Student Society

Volunteering & Electives

Editor's Notes

Tiffany Lin

Publications Co-Chair

2nd Year Medical Student

To escape from PBLs, OSCEs and endless nights of memorising the common conditions, many of us choose to enrich our medical degree with volunteer work. Volunteering is a great way to have a meaningful and positive impact on others, and a perfect medium to discover new passions, consolidate practical skills.

This issue is packed with anecdotes from your fellow students – ranging from St. John

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Ambulance work in Geelong and John Flynn placement in Queensland to cardiology in East Timor and Specialists Without Borders in Africa.

Whether locally, interstate or internationally, each of us who has volunteered has a story to tell, insights to share and bizarre experiences to laugh about.

We hope this issue brings you joy, wonder and possibly some inspiration for your own future endeavours!

John Flynn Placement – Gin Gin, Queensland

Elina Ziukelis

2nd Year Medical Student

I was fortunate enough to spend two weeks in Gin Gin, 380km NW of Brisbane on the highway to Cairns. The population of Gin Gin just breaks one thousand. This includes sugar cane, cattle, citrus, macadamia nut and honey farmers but the town has an unemployment rate close to 20% and much of the community is socioeconomically disadvantaged.

This is the most northern country town in Australia I have visited. I found the palm trees and pink cordylines among gum trees and fields of cattle very strange! Having arrived two days after finishing exams, the colourful landscape, intense warmth and occasional spectacular thunderstorm were revitalising.

I shadowed Dr. A* at Gin Gin Family Medical Centre. Dr. A is also one of only two doctors that staff the 10-bed Gin Gin Hospital. Each day started with ward rounds at the hospital. Then we would attend the clinic less than 100m away for the day's appointments (typically 35-40). Dr. A was on call at the hospital for most of my placement. This meant that on some days, his phone rang incessantly during and between appointments. On most occasions he was able to give advice to the ED nurses over the phone but sometimes we had to attend the hospital, putting all of his appointments on hold and showing me how demanding rural practice can be.

The opportunity to observe several hundred consultations was invaluable. While Dr. Ismail did not have time to explain every patient's history, he took the time to do this for particularly interesting cases and welcomed questions. If I hadn't heard of an illness he would ask me to find out about it and report back to him, the process of which helped me to commit the new information to memory and occasionally taught him something too. After the friendly nurses in the hospital tutored me in injections, venepuncture and cannulation, I was allowed to give all of the B_{12} injections and vaccinations,

take blood, put a cannula in and administer the local anaesthetic for skin surgery.

I was present for two emergencies that were taken by ambulance to Bundaberg Base Hospital. Having virtually no clinical experience, my heart sank when one man kept transiently losing consciousness and when one woman's blood pressure dropped to 70/30. Dr. A coolly instructed a room full of hands, pausing to think with each new piece of information and to balance the needs of a waiting room full of patients at his clinic with the risk in sending the casualty on the 45-minute ambulance drive without him.

I admired the way that Dr. A, though run off his feet, never made this obvious to his patients. He still took the time to ask them about their farm or their family or how they have been feeling. He still addressed the complex problem brought up casually as an appointment was finishing. He still sometimes emptied a cupboard full of drug samples looking for what the patient would not otherwise afford.

Each night when the clinic closed I had dinner with my host family and with another medical student on placement in the town. Sometimes we joined others, including the owners of the first Gin Gin cattle station at their beautiful 1400-acre property, the local ESA group and the teaching staff of Gin Gin School. In contrast to the many disadvantaged patients I saw at the clinic, many of these people had strikingly healthy lifestyles. The sense of community was strong. Neighbours that lived hundreds of metres away were as close as family. Colleagues were friends. The children spent more time outdoors than they did watching television or playing video games. Most meals were homemade, often with local produce.

Because Dr. A is a young doctor who had previously always lived in the city and was reluctant to take his position in Gin Gin, I found his perspective on rural practice to be especially meaningful. He does not keep it a secret that he misses the city but emphasised how personally and professionally valuable his time in Gin Gin has been, particularly for testing his ability to handle complex situations independently and increasing his confidence in doing so. In order to reduce the sense of isolation and to have something to look forward to during stressful and laborious weeks on call, he regularly retreats to the nearby coast on his days off. He also occasionally recommended this to low-spirited patients who, when questioned, said they felt overworked, trapped, or tired of the town. I realised that I don't have to love everything about a town to make

moving there one of the best things I ever did. Especially when the nearby coast happens to include the southern-most part of the Great Barrier Reef.

I also began to appreciate just how highly continuity of care and a close relationship with the doctor is valued in a place where people know that it can't be taken for granted. Every patient that heard Dr. A would soon be taking holidays and would be replaced by a locum was eager to know that he would definitely come back. Nobody wanted to change doctors *again*, particularly as this one was well liked and trusted.

Apart from allowing valuable insight into rural life and healthcare, the John Flynn Placement Program fosters confidence and early development of the extensive skill set a rural doctor ideally needs. I'm very grateful for the opportunity to be a part of it and can't wait for my next placement.

**Name has been changed to protect privacy*

A Good Dose of Hamilton

Nufail Khan

Preclinical President/2nd Year Medical Student

Content and use of photos have been approved by Ben Condon, Liz Armstrong, Michael Hand, Community Liaison and the CEO at WDHS, Hamilton."

The arrival of the mid-semester break in Semester 2 of second year, brings the awareness that there are no further 'Knowledge of Health and Illness' (KHI) topics and their associated 'Learning Objectives (LO)' to deal with ever again! Additionally, the first half this semester culminates with a fantastic change of pace, and for me, a wonderful perspective of clinical life in a rural or regional locality. After 1.5 years of LOs, I was definitely in need of a dose of Hamilton.

Medicine at Deakin is structured differently from other universities, such that our clinical years begin after two years of preclinical University-based study. Therefore any clinical

exposure we receive in these so-called 'preclinical' years are eagerly anticipated by many students, especially those who have not previously worked in health care.

As part of a holistic approach to teaching medicine, the School introduces us to their interprofessional collaboration learning module, and the idea that optimal care and treatment of patients requires interaction with other health services such as nursing and allied health (physiotherapists, pharmacists etc). This learning module finishes with a one-week clinical placement to experience and understand interprofessional collaboration. I chose to go out west, and experience what Hamilton Base Hospital had to offer.

Sue Hillier at Western District Health Service organised the placement and provided a structured timetable which was brilliant for me. Although I could have simply spent the week on 'holiday' mode, I took the opportunity at hand to gain insight into how other professions view physicians, and especially the negative aspects. This for me is critical to try and mould myself differently to be the best physician I could be in an atmosphere of collaborative work. As a future doctor, I couldn't learn enough in this week.

As some examples, the palliative care nurse, Jacqui Page emphasised to always consider

engaging with their services early to ensure appropriate services are instigated early on. The pharmacists including Suzy Staude and Adam highlighted that there is a high rate (87%) of incorrectly completed scripts which can easily be reduced by taking some responsibility and using the Victorian Department of Health website and resources (Therapeutic Guidelines, PBS site, AMH site). Furthermore a number of allied health professionals including the OT and physiotherapists mentioned that it would be worthwhile if practitioners made an effort to be part of the multidisciplinary meetings that typically only involves allied health workers. I agree and see the benefits of this.

Thanks to so many who graciously accepted me as their shadow no matter how frustrating that must have been, from across podiatry, palliative care (Jacqui), continence (Sue Langley and Tara), OT (Brianna and Fiona), National Centre for Farmer Health (Dr. Vanessa Vaughan), Physical Activity Group (Brenda, Stacy and Will), Pharmacy (Suzy Staude, Adam, Jules and Julie) and of course the Physios (especially Cath, Stefan and Laura) (I loved the afternoon session, of "how many physios does it take to figure out how the new tilt-table works?").

Apart from the learning experience, the lifestyle

was just sublime. As I usually spend hours commuting to and from university in Waurn Ponds, it was a refreshing change to wake up and literally walk across the road from my house to reach the Hamilton House (allied health service). I even had a chance to run around Hamilton before placement started at 8.30am including Lake Hamilton and along the main street in town.

I was fortunate to also spend this week with three other students, Liz Armstrong, Ben Condon and Michael Hand, and they were great company throughout the week including the group day out with the National Center for Famers Health (NCFH). These 3 ensured I was well nourished each morning, with hot chocolate from Tosca Brown, which is the talk of the town. We also managed to have some nice breakfast there as well on one occasion.

We tried to get out and about around Hamilton whenever possible and before sunset after our day on placement, and fell in love with the local café bar and pizzeria set in a 2-storey bluestone building, The Roxburgh. Their dessert pizza….is a must try! The PHM team would be disappointed however in our indulgence at the local pub, 'The Cally'. Their serving of food was enormous but delicious.

A special mention must be made of the dinner put on by Michael Hand at his 'student' accommodation, which in fact seemed to be a scene out of a Jane Austen novel. Just a beautiful residence.

At the end of it all, this was a learning experience, and an overarching concept that I gathered from all services that I was partnered with over the week, was to always hold onto my empathy, and to always remember to remain open to suggestions regardless of status or standing. The allied health services are amazing resources, and this placement has reassured me of the supporting nature of the health professional environment that exists in such hospitals. The placement had such an amazing impact on me, that I regret not being able to spend my clinical year at Hamilton Base Hospital. Nonetheless, I hope that my clinical school will also encompass the supportive environment in which I found myself during the course of this week.

I also hope Deakin University and the School of Medicine continue to provide this unique and fantastic opportunity for future med students. I took a lot away from this week, and thanks to all involved.

Volunteering Abroad in East Timor

Tess Langmaid

MeDUSA Vice President/3rd Year Medical Student

This September I had the privilege of volunteering in Timor-Leste with the East Timor Hearts Fund (ETHF), an organisation that arranges for Timorese patients with cardiac conditions to have surgery in Australia. Although we were only there for four days, we saw over 100 patients at both the Baro Pide Clinic in Dili and the hospital in Baucau. During this time I encountered a vast array of cardiac disease, such as rheumatic valve disease, patent ductus arteriosus and Tetralogy of Fallot, to name a few. For each patient we saw I had the chance to perform a brief cardiac examination, present my findings and possible differentials, and then interpret the echocardiogram in real time.

In addition to those patients who were being assessed for surgery, we also reviewed patients who had received treatment in Australia in past years. Seeing these patients return to the clinic healthy and thriving really highlighted just how much of an impact projects like these can make to people's lives.

Cardiologist Dr. Noel Bayley has been leading these trips and providing this invaluable service to Timor-Leste for more than 10 years. Every trip, Dr. Bayley invites two Warrnambool third year students to join him, and myself and Jun were fortunate enough to accompany him this semester. I would highly recommend any future Warrnambool students to consider applying for this unique opportunity. If you are interested, further information about the trip and the application process will be provided by Cara English (Warrnambool Clinical School Administrative Coordinator), or you can email me at tlangmai@deakin.edu.au. You can read more about the East Timor Health Fund at www.easttimorheartsfund.org.au.

Exploring The Unique Potential We Share

Annie Rose

4th Year Medical Student

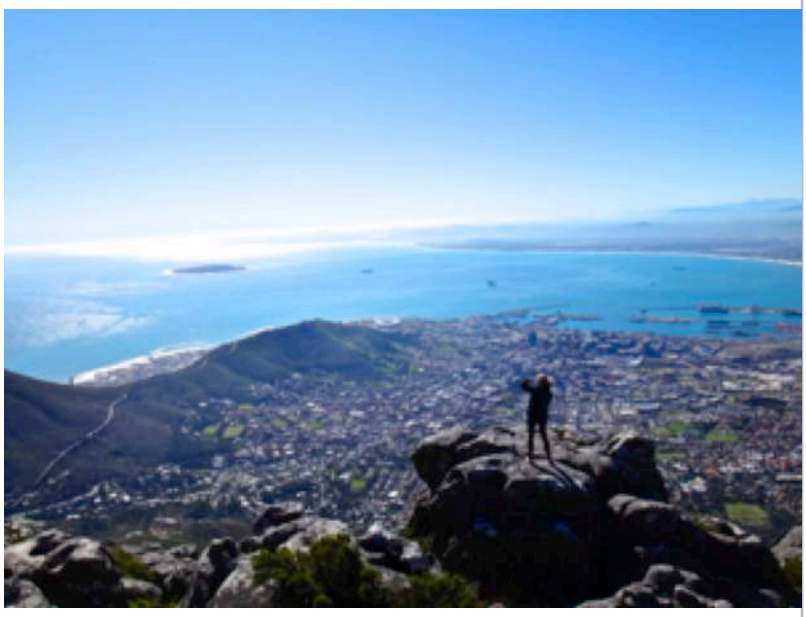
This past 12 months has seen women of the medical world sustain a particularly strong focus on the complex issues of bullying and harassment in our workplaces. As we continue to negotiate these matters, I would like to encourage you to take a moment to reflect on the distinct contributions to the health and empowerment of women that we, as a female health providers, can have on a more global scale.

I recently returned from a most inspiring medical student elective in South Africa. I was based largely in an emergency department in Cape Town, but spent time working with the local volunteer organization SHAWCO – a University of Cape Town student-run outreach program, delivering primary health care in under-resourced communities. During my six weeks in the country, I was reminded on a daily basis of how lucky we are to live, receive our education, and work as females in Australia. Despite the long-standing discrimination still impacting women in our chosen profession, we have come such a long way from the sexism and discrimination experienced by our predecessors.

Whilst on elective, I experienced the National South African celebration of 'Women's Day' on the 9th of August. This holiday commemorates the strength and resilience of women during the resistance, remembering, in particular, the day in 1956 when 20,000 women of all races came together to challenge an oppressive government and petition against racist legislation during Apartheid. However, rape, domestic violence and issues relating to gender inequality are still way too prevalent in a country that has come so far in the fight against discrimination.

Women are observably under-represented in senior medical positions within the South African hospitals I visited, yet over-represented within the local medical student cohort. I also noted that females were grossly under-represented amongst the many overseas students and volunteers I met along the way – which to many may not be overly surprising. A lone female venturing across the world to work in a country with such a notoriously prominent crime rate is not viewed by all as a sensible idea. However, as I have experienced, it is women undertaking these roles overseas who contribute to the gradual acceptance of women as doctors and who consequently aid in the breaking down of disempowerment of women.

Whilst volunteering as a physio in Papua New Guinea several years ago, my time spent with a group of international female doctors was the inspiration for my own pursuit of further education and a career in medicine. These volunteers conferred how important the presence of educated women, actively taking part in local communities and leading in positions of power, were for these communities. In a role still often dominated by white, male medics and volunteers, working as a female health care professional



overseas often permits our female patients to divulge important health related information. It has also been shown to promote help seeking behaviors in women who might have otherwise felt obstructed by societal norms and local culture. Moreover, it is the ability of female health workers to educate and inspire local women to advocate for themselves that reaps the greatest rewards for a community. Much of our contributions to poverty alleviation tend to emphasize bottom tier measures, such as provision of pharmaceuticals, when we know that it is the empowerment locals - women in particular - who often have the biggest impact on a community's health and development.

Obviously, working and volunteering in developing nations is not always a solely altruistic venture. It can often be extremely valuable for career development, may offer opportunities for specific skills procurement or practice (I did a hell of a lot of lumbar punctures and chest drains in Cape Town!), or might just be an opportunity to escape to some warmer weather and interesting cultural experiences!

But regardless of motives, I believe that experience outside Australia in third world, male dominated cultures is paramount to females understanding and appreciating what we do have in Australia. These experiences have certainly given me the confidence to work hard for what I want and what I am entitled to as a woman in the health sector. Education is the key to empowerment of women, whether it be within the medical fraternity within Australia or in a developing society abroad. Just I was inspired to become a doctor by amazing women working overseas, I hope to enable other women to recognize their potential and the important role they can play in the fight against poverty and discrimination against women.

To our fantastic body of strong-willed medical students and junior doctors currently pondering career paths: I highly recommend taking a break from dwelling on the things our society suggests you ***can't*** do with your future, and instead explore the unique potential and amazing opportunities that this career ***can*** offer both you and women world-wide.

St. John Ambulance

So much more than a CV filler

Elisa Pruss

2nd Year Medical Student

Being a good doctor is often associated with being a charitable personality. Those who choose the profession therefore, naturally choose volunteering as an extra-curricular activity or hobby. It is also often suggested that leadership skills are essential. However, "strong leadership" and "service" are concepts which sometimes may be considered to clash at first superficial glance. Upon deeper consideration, the two can be married in the somewhat paradoxical idea of "servant leadership", where someone may lead by example, rather than delegation. This concept strongly embodies the typical personality who undertakes the medical profession. Volunteering opportunities which nurture the development of both of these qualities have always been more appealing to me, therefore, than simply being involving in pursuits which only allow development of one's community involvement.

Volunteering with St John Ambulance enables development of leadership skills, gives an excellent opportunity for community involvement and service as well as furthering clinical experience. A St John Ambulance member is recognised by the community as a person of responsibility, someone they can trust when they are vulnerable. Many go out of their way to express gratitude for your work and Geelong residents are generally a lovely group of people to serve as a community. It is a very rewarding volunteering role for these reasons.

Leadership skills are taught in the context of clinical situations. Through continued experience at local events, I was able to gain enough experience to train to become a "first responder" which gives me the responsibility to lead first aid response when incidents occur, supervising "first aiders" to administer first aid treatment.

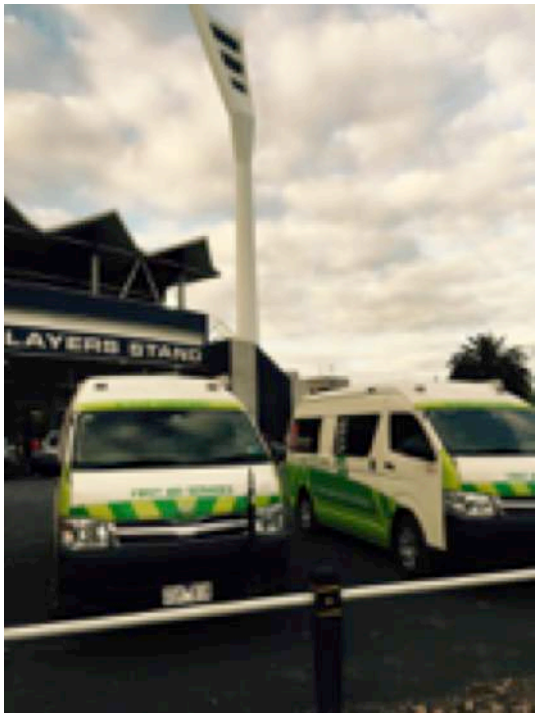
Leading first aid response is possible at both local divisional events and large state events, where more clinical experience is often gained due to the larger volume of event patrons. Involvement at concerts and festivals can involve treating patients who are affected by drugs and alcohol, a particular clinical situation which is quite different to those we are typically exposed to in medical school. Once qualified as a doctor it is also possible to work within the scope of your profession. This becomes a leadership opportunity in its own right, as other healthcare practitioners, such as nurses, will also work within their scope of practice at large events,

transforming the first aid situation into a very similar collaborative environment to that in which we will participate within hospitals upon graduation.

The training opportunities within St John Ambulance give options to further clinical experience. First Responders are very well trained in triage, spinal injury management, and fracture management. These are certainly important skills to gain exposure to if interested in a future as an Emergency Physician, but equally important for all medical graduates, since internship requires rotations in emergency. St John Ambulance also has the capacity to assist in Emergency Management response, such as in floods and bushfires.

Volunteer members of St John Ambulance can become qualified to attend staging areas and community relief centres to assist community members and other personnel in the Emergency Management response, such as firefighters. Involvement in St John Ambulance is an excellent inclusion in a Curriculum Vitae, though I hope the reader can appreciate the message this article puts forth, that volunteering in St John Ambulance adds so much more than this to one's professional repertoire.

Personally, I have found St John Ambulance a good opportunity to practice my own clinical skills. From important advice to give when administering paracetamol, to knowing how to handle a diaphoretic, pale and tachypnoeic man complaining of chest pain, my skills have been tested in such a way as to keep me on my feet. I have also practiced the 4 x 4 x 4 protocol for asthma management, simple wound dressing, medical documentation, clinical handovers, neurological assessment following head-strike and history taking.



The experiences I have found most memorable, however, have been enjoying local events. A few highlights include: the football, seeing the Jezabels perform live, seeing beautiful countryside in the outskirts of Geelong, checking out the very expensive Jaguar owned by the organiser of the Harry Kewell Soccer Academy, seeing fireworks at festivals, purchasing many ice-creams on warm sunny days, seeing the fantastically awe-inspiring Avalon Airshow, and meeting Eddie Perfect. But the best experience by far, was the sense of community being part of an organisation like St John Ambulance, and the lovely people I have met in the Barwon Division #BarwonDifference.

No Jab, No Payment – No Fair

Dominic Walpole

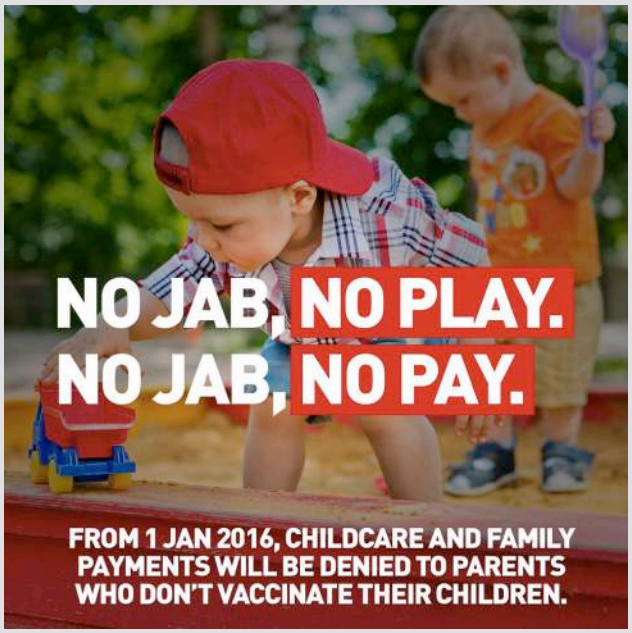
1st Year Medical Student

The government's new vaccination policy raises some important questions around health policy. The issue of child immunization highlights the tension between individual rights and the public good, which exists across many areas of public health. Policy makers should seek to strike the right balance between these two ideals, but they must do so equitably. In this instance, it seems to be a case of 'No Jab, No Payment – No Fair.'

The benefits of vaccination are undeniable. People who are immunized have a hugely reduced chance of suffering from many harmful diseases. And due to the infectious nature of these diseases, vaccination protects not just the individual, but also the whole community. Vaccines are one of the best public health measures in terms of their safety and cost effectiveness.

Yet despite the benefits of vaccination, some people do not wish to have their children immunized. In one sense this poses a challenge for advocacy and patient education for the health profession. In another sense it represents a genuine individual health preference. Vaccination is not entirely without risk, there are in rare cases serious adverse reactions. Some people may weigh these risks differently and choose not to have their children vaccinated. Others may refuse for entirely different reasons. Who are we to say that they should not have this right? After all, patient autonomy is a key principle of health care.

Whether or not we choose to respect individual rights or protect the public good has been called the 'central dilemma' in public health. Maybe we should mandate certain health requirements for



all people, or perhaps individual liberty should always prevail. This tension exists for many health issues and there are valid arguments for both sides. The purpose of this essay is not to argue one way or the other. It is the role of policy makers to determine the right balance on any particular issue.

The use of financial incentives or disincentives, such as taxes, can allow policy makers to take a balanced approach to the central dilemma. These sorts of measures can encourage people to act in the public interest, while allowing obstinate individuals enough latitude to realize their personal preferences. Obviously, not all health problems can, or should, be addressed in this way, however, incentives or disincentives can be an effective policy tool in some circumstances. They are perhaps a suitable approach for lifting vaccination rates, where the aim is to achieve 'herd immunity' not necessarily 100% coverage. The 'No Jab, No Payment' policy set to come into

effect from 1 January 2016, creates a financial disincentive for parents who do vaccinate their children.

The problem with the government's new policy is not that it will be ineffective, but that it is unfair. To use Tony Abbott's language it is "plainly" unfair. The policy requires parents to vaccinate their children according to the government schedule in order to be eligible for child-care and family tax benefits, unless they can gain an exemption under the policy rules. These welfare payments are means tested, meaning that for a given family make-up the level of payment decreases as household income increases until it is cut off completely. Therefore, withdrawing eligibility for these benefits from a particular group, such as non-vaccinating parents, has a greater impact on low-income families. Non-compliance could cost disadvantaged families up to $15,000 per annum, whereas high-income families face zero disincentive.

These are the policy failures we should strive to avoid when taking a balanced approach to the central dilemma. Namely, that the disadvantaged face strong financial coercion, while the advantaged go untouched by public policy. This unfairly skews individuals' rights based on their relative level of advantage. The same problems arise for any policy that uses welfare restrictions as a policy tool, such as the 'Healthy Welfare Card' planned for trials next year.

Those who say that the wealthy have earned this greater freedom compared to those on welfare, misunderstand the nature of disadvantage and the purpose of redistributive justice.

Some may argue that such welfare measures are simply targeted policy, as the problems are concentrated within low-socioeconomic groups. However, it may not be so simple with data from the national Health Performance Authority indicating relatively low vaccination rates in affluent suburbs of Melbourne and Sydney. Rather than being targets policy, these

sorts of measures partly embody the government's prejudiced and lazy inclination to degrade the rights of the most vulnerable in society whenever there is a problem. Regardless of the distribution of a particular health problem, policy that captures the entire public would be effective. And more importantly this sort of broad policy can ensure that the appropriate balance between individual rights and the public interest is applied fairly to all.

The AMA supports the 'No Jab, No Payment' policy with President Brian Owler stating, "Whatever we can do to increase vaccination is important." The policy will likely lift vaccination rates and despite its unfairness, may cause little harm. But the government should not continue with health policy in this way.

The tension between individual rights and the public good exists for many health issues, especially in the context of a publically funded universal health system. With rising public healthcare costs it may be tempting and perhaps justifiable to shift the balance towards the public good. A range of methods could be used to encourage preventative action and healthy behaviours at the individual level.

However, with the burden of disease often concentrated amongst the disadvantaged, policy makers should take care not to unfairly target the vulnerable or further entrench inequality - to do so would be counter-productive.

Tony Abbott may have earned two Blues for boxing at university, but he's delivering these jabs with poor form. In the future the government should aim for fairer health policy, rather than taking a swing at the easiest target.

A World Away

13 days in South Africa, Malawi and Zimbabwe

Yang Wang, 2nd Year Medical Student

It's 0530 local time as we disembark onto the tarmac, my visual and auditory cortices abuzz with the unfamiliar sights and sounds of arriving in a new country. As soon as we had landed, we meet up with the rest of the team that flew over the day before for a connecting flight. There were 21 of us in total, 8 specialists, 5 nurses, 3 interns/residents and 5 medical students. It was incredible to find out that whilst the majority came from metropolitan Melbourne, we had a urologist and orthopaedic surgeon from Adelaide, a cardiothoracic surgeon from Canberra and 2 general surgeons from Sydney. This was to be the start of my trip with Specialists Without Borders, an Australia based organization that promotes sustainable medical education in developing countries.

For three days, we were based at Lilongwe, the capital city of Malawi. The country is in the lowest tenth of the United Nations Human Development Index, ranking 174 out of 187 countries and will not meet the key Millennium Development Goals. On the health front, over half of the 16 million people live in poverty and life expectancy at birth is 58 for males and 61 for females.

2015 SWB team with some of the local attendees

Most of our time was spent at the medical schools in Malawi and Zimbabwe where the doctor and nurse teams would lead training seminars for the local health students, medical officers and nurses. A typical day would start with large group lectures followed by small group interactive modules where attendees would be given talks from trauma cases to obstetric emergencies, massive transfusion guidelines to imaging for shattered kidneys. It was amazing to watch the orthopaedic surgeon bring his kit along all the way from Australia and show a group of local surgical registrars how to do external fixations of the ankle.

Having a bit of downtime between formal teaching sessions, we were given the opportunity to have a look at the local hospital. Walking around the wards, it was a brief glimpse of the lack of resources that another country's health system faced. One of the doctors commented that health funding would be released at the start of the month, and money would to run out within a fortnight. The wards were a similar size as the ones you would find in Australia albeit there were more people per room. As the day progressed, the beds would fill up and mattresses would be placed on the floor for patients or their family members to lie on. There were no privacy curtains, vital sign monitors or even hand-washing bottles anywhere to be found. Despite this, I saw multiple accounts of ingenious ways the hospital overcame these resource challenges. For example, for phototherapy of newborns with jaundice, a wooden box would be set up with a simple UV light on top of a Perspex cover and their triage system for hospital admissions incorporated more primary health doctors and day clinics.

The interactions with the local doctors and medical students, not so different to ourselves, made us

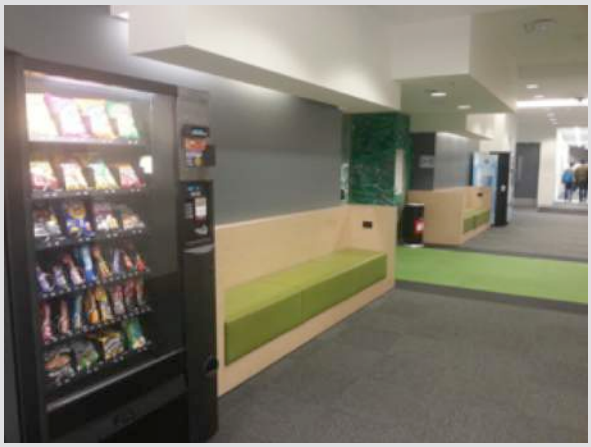
consider the immense privilege to be living and studying in Australia. We have the fortune to be removed from civil unrest and personal threats to safety, to be able to work within a structured and well-funded health care system, to have the technology to investigate, diagnose and practice evidence based medicine. It was difficult to overcome the frustrating realisation of how little we could do given the short amount of time that we were there. As I was going over the feedback forms, I realised that all the local doctors really enjoyed the seminars. With every bit of education, every newly acquired skill, they would be better equipped to treat patients and more importantly, the knowledge would be passed on to others, translated into action, and the goal of improving healthcare would be possible.

I went on this trip not knowing what to expect. I walked out of Melbourne Airport with new friends, priceless memories, a greater perspective of my role as a future health practitioner and an optimism, knowing that there are no geographical limits to where your practice of medicine takes you.

Specialists Without Borders hosts annual trips around September to Africa. I would strongly encourage anyone who is interested in global health and meeting an amazing group of doctors and nurses and medical students to apply!

What do vending machines have to do with public health?

Associate Professor Colin Bell

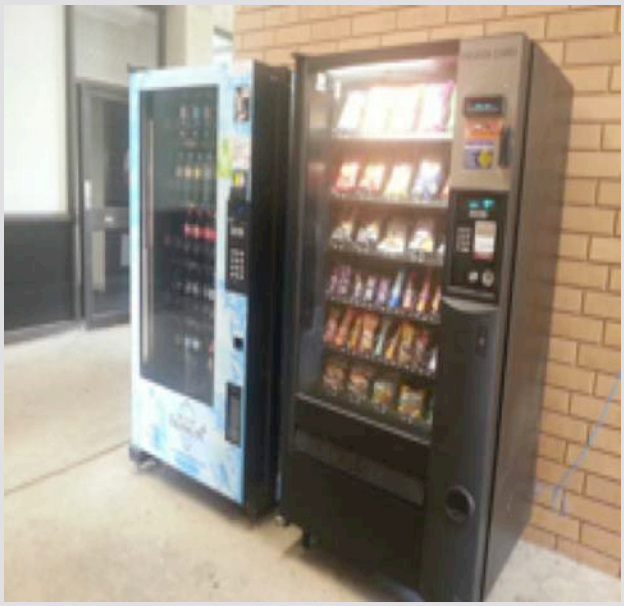


Vending machines outside the Deakin School of Medicine PBL corridor

If you missed breakfast or are rushing from one place to another with hunger pains I suspect a well-placed vending machine is something of a lifesaver, quenching your thirst or giving you the energy hit you need to get through an ELPD lecture. Another possibility is that you couldn't care less about vending machines. They are just there.

A third perspective is that vending machines, far from being lifesavers, are silent killers. If you think about the unhealthy foods and beverages that are typically available from vending machines and the number of times you have filled a machine with coins when you weren't actually hungry, you start to realize that vending machines are exposing you to more calories than you need. I once took the time to add up the energy available from a snack vending machine. It came to 389,000 kilojoules (or 93,000 calories) mostly from 5.5kg of sugar and 4.4 kg of fat. A machine serving drinks (a quarter of which were diet drinks) contained 239,000 kJ's (or 57,000 calories) from 14kg of sugar. On top of all that sugar and fat, vending machines also assault you with advertising and to make matters worse, they are placed in every conceivable location. Two of them stand like totems outside the School of Medicine PBL corridor.

With the outstanding teaching you receive from the humble public health medicine team at Deakin, you will increasingly recognize how environmental influences, like availability of vending machines, contribute to disease risk.



Vending machines outside the library at Deakin Waurn Ponds campus

Leadership in public health involves recognizing subtle but critical influences on health and caring enough to do something about them.

The 'Global Health Unzipped' symposium hosted by UHAD in August demonstrated such leadership. Other examples include recent poster presentations from third year students Elizabeth Forsyth and Kirk Underwood. Elizabeth identified a reading program as a solution to developmental vulnerability in Ballarat children and Kirk highlighted food insecurity in Wimmera youth. Both subtle but critical influences on health.

Advocacy in public health is getting other people to care too.

Describing vending machines as silent killers is intentionally provocative. In the past I have described them as a form of biological warfare with the aim of provoking people to care enough to take action. And what action can you take? In hospitals in the Hunter New England local health district of NSW, contracting arrangements require that vending machines include and label healthy options. Most schools in Australia have banned vending machines.

Healthy option labeling on a vending machine

Perhaps @DeakinWellbeing could encourage similar changes at Deakin led by @DeakinMedicine students?

Disclaimer: Colin is the Public Health Medicine theme leader and has nothing against Ethics, Law and Professional Development. Colin once had to apologize to the PVC-Health at Deakin because a reporter had rung him at 0630 in the morning to respond to an article Colin had written for the Herald Sun about vending machines.

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