The age-old public health metaphor: Standing at the riverside, you notice a distressed person floating past and drowning. You act quickly to pull them out and begin resuscitation. Shortly afterwards, you see another person floating past and another and another. You soon find yourself exhausted and realise you cannot save all them all. You walk upstream to find out why these people are falling into the river. You discover a bridge is broken and a group of people who are trying to cross it are falling in. What do you do? Do you decide to fix the bridge? Or keep fishing them out as they fall in?

This scenario reflects every standard emergency department around New Zealand - where no chair goes unoccupied and the waiting room is always full. As a house officer, I saw patients overflow to sitting outside in their cars and the ambulance bay busier than the local supermarket carpark on Christmas eve. Inside, the department runs 24/7. Staff are drinking cups of coffee. Stone cold. There is a constant search for room 10’s notes and during the peak hours, the manager stands centre floor looking like they should be holding two orange flags, directing aeroplanes rather than the new admission.

“My on-call days were never dull. I was constantly running between the emergency department and four acutely unwell patients on the wards. Clutching cannulas and catheters, it was not long before I soon joined the cold coffee drinking group and begged to never say the ‘Q-word’ again (FYI: The Q-word refers to ‘quiet’, for when spoken of, one can rapidly increase staff anxiety and become the recipient of several death stares.)
This is for being the sole person responsible for changing the environment from a peaceful haven to a chaotic war zone).

In (quiet) times however, I would often think about the bigger picture of health – as if the patients I attended to were those floating down the river. It led to many internalised questions. Why am I admitting the same four-year-old child for the fifth time this year? Why do some populations remain worse off than others? Why does our country continue to welcome in fast food outlets despite our high rates of obesity and diabetes? In the end, the greatest question of all surfaced and unknowingly shaped my choice of specialty – what bridge could I be fixing?

Enter the realm of Public Health Medicine and suddenly I could not look at the world the same again. Similar to Neo taking the blue pill in The Matrix movie, the answers to the questions I had, now lay in front of me. An entire new perspective has unfolded – one that could not be learned from a clinical textbook, but relies on connecting the dots between politics, infrastructure, environmental challenges, historical influences and emerging disease – to name a few. I have only completed my first year of registrar training but in summary, Public Health Medicine is like a pair of really good sunglasses. When putting them on, suddenly that chronic glare has gone, and everything becomes clear and interesting to look at.

So, what is upstream? Well, many bridges. Many, many broken, washed out bridges. But, the reality is fixing these bridges is not as simple as it seems. It is not unusual to encounter other groups upstream. These can include the likes of larger industries who propose to dam the river and redivert the flow. Or perhaps we find there are groups making new river crossings without returning to monitor the effect (usually a pile of sticks bundled just high enough out of the water to be considered a ‘crossing’). Some groups will put up signs, telling people not to cross, without realising no one reads English. Or it may have operating hours between 8am-4pm, catering only to certain populations. Of course, don’t forget there is climate change where a warming of 1.5-degree Celsius increases the rise of river levels leaving the whole region is at risk of flood.

...Perhaps my focus in the interim should be on teaching people to swim.