GONE FISHIN'

April 2006 Edition - a newsletter for RAMUS Scholars, Mentors and Alumnus Members

From the Manager….

We hope that those in and near Innisfail, Maningrida and in WA dealing with the cyclones and their aftermath, others affected by flooding in Katherine and yet others from bushfire-affected areas and their families and friends have been all right. We heard earlier in the year that some applicants and scholars were fighting fires with their local brigades.

Recently 122 medical students received RAMUS scholarship offers in the 2006 round from over 370 applications received. A very warm welcome to all of the new RAMUS scholars and mentors.

At the end of 2005 116 RAMUS scholars graduated from medicine at university. This included the graduation of over 60 of the first medical students who were awarded RAMUS scholarships when the scheme began in 2000. All have been sent their certificates of completion and invitations to become members of the RAMUS Alumnus. Their mentors have also been invited to membership of the Alumnus and we look forward to welcoming all.

Among the completing and continuing scholars, several spent the summer break working in a variety of placements ranging from East Timor to Guatemala while others worked in rural and remote communities in Australia with their mentors. *Beyond Borders: Guide to Health Placements* (McGraw-Hill) by Hamish Graham, a RAMUS scholar from Devonport who graduated from Monash University at the end of 2005, was published recently. This is a useful guide for students and health professionals. Emma Goeman from Ballarat is another former RAMUS scholar also in the news. The Age has published two in a series of articles following her experiences as an intern, most recently in on rotation in Hotham. She graduated from the University of Melbourne at the end of 2005.

The RAMUS Alumnus Ambassadors have started their teleconferences and we will report to you on developments in the next newsletter.

Lots to look forward to this year,
Margaret

Contact RAMUS!

Free Call 1800 460 440
Fax 02 6285 4670

Address PO Box 280, Deakin West, ACT 2600
Email ramus@ruralhealth.org.au

In This Issue!

RAMUS Reminders..... 2
NRHN Updates .....….... 3-4
Scholars Articles ……. 4-9
Staff Update.....…... 9

IMPORTANT

Please remember

- You *must* contact the RAMUS Office immediately if anything changes – your status as a student (repeating, deferring, returning from deferral, withdrawing etc) or address or phone number or email address or bank details etc.
- Proof of rural health club membership is already due. Also, Learning Plans are due on 1 June 2006.
- Please send more photos of RAMUS scholars in groups, individually, with mentors, on location, and Alumnus members. We would like to feature you in new publications and web pages. Add to the RAMUS collection by 15 May 2006.

If you're a New Scholar... ***you may still not have located a mentor to participate in the Rural Doctor Mentor Program. Here are some things to keep in mind:***

1. **Your mentor must have spent some years of practice in a rural area. We recommend that you consider contacting a rural GP or medical practitioner from your home town or a GP with whom you already have a relationship.**
2. **You are required to have contact with your mentor at least four times each year. This contact may be over the telephone or through email, with at least one face-to-face meeting each year. Whether the face-to-face mentor contact occurs as a clinical placement is a matter for decision between mentor and scholar.**
3. **The benefits of the Rural Doctor Mentor Program vary among scholars and depend upon particular arrangements between a scholar and mentor. Working through your Learning Plan with your mentor is a mutually beneficial experience. The rural activities you list in your Learning Plan may include spending some time with your mentor in their day-to-day work, etc. Levels of involvement may differ and will contribute to determining how much you get out of the scheme.**
4. **It is important for you to have a good relationship with your mentor. If the arrangement is not working for you, it is important to let us know first and then to identify a different mentor.**
5. **Remember to let us know if your mentor details change.**

Good luck and don't hesitate to contact us on 1800 460 440 or ramus@ruralhealth.org.au if you require further assistance.

National Rural Health Network (NRHN) UPDATE

NRHN held its Annual Face-to-Face Meeting in Canberra in February. In 2006 NRHN is focused on achieving the following goals:

- To investigate placement issues and key factors such as access and support that are influencing student decisions regarding work in rural and remote areas. The focus in 2006 is the development, distribution and retrieval of a survey on these issues.
- Development of a web-based resource enhancing NRHN's corporate identity and providing a forum that will help identify needs of the NRHN constituency and the broader rural community.
- Development of a graduate tracking system to track medical, nursing and allied health students and how they are influencing the rural/remote workforce
- To upgrade the rural high school visits program and other interactive programs, such as CrocFest, to foster and promote the positive experiences of current and future health students and their future careers in rural/remote Australia

**Please see page 3 for further information about the National Rural Health Network.*

National Rural Health Network – 'Harnessing Good Intent'
Lana Prout
MBBS 3 – Monash University
WILDFIRE

For those of you who don't already know, as a RAMUS scholar, and therefore a rural health club member, you are automatically a member of the National Rural Health Network!

The National Rural Health Network (NRHN) was established in 1996 following the inaugural Undergraduate Medical Students' Conference in Kalgoorlie in 1995. Since that time it has grown as a student organisation and is now the peak national body representing medical, nursing, and allied health students with a common interest and passion for rural health.

The NRHN harnesses the passion of health students through representation, networking, professional development and initiatives to increase the health workforce and health outcomes for rural and remote Australians. The network is now made up of 19 university rural health clubs (with lots of unusual acronyms!) located around Australia, with at least one in every state and territory. The NRHN prides itself on its multidisciplinary membership base of approximately 5000 students covering medical, nursing and allied health courses.

In 2005, along with many other projects such as CrocFest, rural high school visits and the development of a Mental Health guide for rural placements ('When the Cow Pat Hits the Windmill'), the network successfully underwent a mandatory governmental review. This was the reason why the much loved National Undergraduate Rural Health Conference had to be postponed. However, don't despair, as the NRHN has big plans for this year's revamped conference. Stay tuned for details!

FACE TO FACE

Every year in February, representatives from each rural health club and the NRHN executive travel to Canberra for the NRHN Council Face-to-Face meeting. Generally, the first two days involve discussions and planning for the year ahead, followed by a day of meeting with a range of rural health organisations, including the lovely people at the National Rural Health Alliance (NRHA), Rural Doctors Association Australia (RDAA), Australian College of Rural and Remote Medicine (ACCRM), just to name a few. The final day consisted of a trip to Parliament House to put forward our plans for the year to various politicians and spread the rural health message!

Face to Face is a great opportunity for each club to put forward its views in a personal forum and this year it all went really well. It was also fantastic to welcome our newest member club, the Australian National University Rural Medical Society (ARMS), to their first NRHN event. The addition of ARMS means that the NRHN now has a club in every state and territory across Australia.

Now, whilst there was a lot of serious debating and work done, it wasn't all hard work…To start each day, all members of the council had to partake in the traditional smorgasbord of ice breakers, bringing us all much closer together. We also managed to finish each day taking in some of the various sights and sounds of our lovely nation's capital.

In essence, the year is young with still much more to do, so get out there and get involved with your local rural health club. After all, you must be members, so why not make the most of it?!

VISIT THE NRHN WEBSITE FOR MORE INFORMATION!
www.nrhn.org

Placement in South Africa
Lawrence Josey
Completed RAMUS Scholar, UNSW 2005

"Tafalofefe is a 280-bed, rural, district hospital situated 18km from the Indian Ocean. It currently has 2 doctors working here and attempting to provide support to 11 community clinics. The hospital provides a comprehensive package of care. This is necessary due to the considerable time and distance to our referral hospital in East London, which is dependent on weather, road conditions and availability of ambulances."
Dr Roger Walsh, Tafalofefe

The above paragraph clearly outlines some of the difficulties that may be associated with working in a rural hospital, particularly one in a region as poor and underdeveloped as the *Transkei* or rather the Eastern Cape as it is now known. The Eastern Cape has a significant history and it is this distinctive past that sets it apart from the other provinces in South Africa and many parts of the world; this creates the healthcare environment which I worked in.

Tafalofefe hospital is situated not in a town, but strangely enough, on its own in the midst of remote South Africa. Two hours drive on rocky, dirt road from the highway and where there are no shops, fuel stations, nothing except a 'shebeen' which is a place to buy alcohol. The hospital is situated on a hill with awesome views of the 'real' South African country side, dotted with rondavels, the circular huts with thatched roofs, skilfully crafted by hand.

Whilst sitting in the hospital grounds one gets to observe the children walking to school, playing, and sometimes greeting us with waves and smiles, or on the odd occasion some distinctly western hand gestures that imply insults. The ladies walk past gracefully, in no hurry and carrying baskets, drums, firewood, water bottles and clothing neatly balanced above their heads. By day the countryside is peaceful yet busy with the hum of activity that rural life requires. By night the rural environment takes on a much more hostile picture and due to the mixture of impoverished conditions, alcohol, and darkness it is very unwise for a white person to venture outside the guarded compound alone. Although the people who work at the hospital are respected and treated with care, alcohol removes the inhibitors from young minds that are desperate for money or something new. With this in mind we spent all of our nights within the hospital compound, surrounded by fencing and a few armed guards. Most nights were passed while enjoying brais, a white South African equivalent of our Aussie BBQ and the days were spent in the hospital assisting with caesareans, tubal ligations performing chest drains and pleural taps, abscess drainage, crude anaesthetic skills, consults with patients and prescribing medications. The practical skills that can and were obtained in Tafalofefe were second to none, and any anxiety one may have with performing procedures is quickly removed through sheer necessity.

Medically the hospital was incredibly lucky to have a skilled physician such as Dr Roger Walsh working there but the medical side of the work for us became quite monotonous due to the volume of HIV and TB patients, lack of resources and the difficulties with obtaining lab results promptly (some LFTs may take up to a week to return). The pathology we saw was not to be laughed at, and on many occasions we came across very extensive clinical disease but the volume and repetition of the HIV patients was somewhat overbearing.

To conclude this brief report, I would like you to read a brief outline of a case I clearly remember that typifies the emotion that one encounters whilst in a 'third world' region and working in poor conditions. Doctor Peter, my supervisor, who is an intern, asked me if I would like to take care of a particular patient. The patient is a 22-year-old male with a large abscess, approximately 6-7 cm in diameter and situated on the lower border of the left side of his jaw line. Nothing was complicating the abscess but I felt a great deal of compassion for this patient due to his level of pain and sensed that Peter would be able to carry out the procedure more rapidly and efficiently than me. I asked if I could simply inject the anaesthetic.

The anaesthetic was injected and the simple procedure began. Due to the non-existence of scalpel blade handles in the hospital, we had to hold the blades on their own, between thumb and index fingers as Peter was now. Peter incised the fluctuance and drew down along its longest border, with blood and inflammatory fluid flowing from the wound Peter drew down further and hit an area of skin that was not anaesthetised. The patient flinched and his hand hit Peter's elbow, launching the blade across Peters index finger and slicing through the glove, with the patient's blood saturating Peter's hand. We stared at the wound. Incidentally, the patient was HIV positive. Peter removed his glove, washed and was thankful to see that the blade had not broken the skin. Sliced the glove, but not the skin. We breathed a sigh of relief that Peter was OK, but I sensed no compassion for the patient at that particular time, rather, it could be described as contempt and also embarrassment that I had perhaps not injected the anaesthetic appropriately.

Whilst working at Tafalofefe I came to realise that to keep the romantic third world image in your mind is almost impossible. With the daily disappointments, lack of support and the variety of emotions that are instigated by being 'thrown in at the deep end' where your mistakes may cost the lives of your colleagues, your patients and in fact yourself, the romantic imagery is replaced by a more realistic perspective. The experience helped me grow and mature as a doctor, as a person and prepared me for the authenticity of life as a professional and not a student protected by the tiers of hierarchy that exist in western hospitals.

previous page:
(l) This is the view from the gates of the compound, the white car is a taxi, usually carrying 10-15 people at a time and the tin shacks are people's homes.

(r) Kids' ward. I think three of them had HIV, two had TB and a couple had burns. Burns were a big problem with children due to the fires used all day for cooking.

this page:
I'm the hippy on the right, standing next to Roger, the managing doctor (one of two who worked there.)

Placement at Airlie Beach, Queensland
Julie Chan
MBBS 4 – Melbourne University

During January 2005, I went on my first John Flynn placement to Airlie Beach. Situated on the north central Queensland coast, this town is a very accessible destination, along the Bruce Highway. It was originally inhabited by the Aboriginal people of the Ngaro tribe, who have now been there for at least 8,000 years.

During the placement, most days were spent at the practice of Dr Paul Squires. Not only is he one of the local general practitioners of Airlie Beach, but he is also the obstetrician and anaesthesist of the practice, performing most of the anaesthetics at Proserpine Hospital. Although I was unable to see any surgery this time around, spending time with him provided me with the opportunity to learn more about antenatal care. I am very much looking forward to seeing some surgery in the future, provided my timing is right. There were also four other doctors at his practice I also sat in with, which allowed me to compare and contrast the different ways they interacted with the patients.

Having only had limited clinical experience in my two years at university, I spent the majority of my time observing and asking questions of the doctors and patients. I was also able to help out where I could, which included improving my blood pressure taking skills. Additionally, in between patients, the receptionists and nurses were really warm and friendly. In fact, while I was there, one of the receptionists had a surprise birthday celebration at the clinic, which was a lot of fun. Such interaction with the people of Airlie Beach proved a great way for me to discover more about the town and its various inhabitants and visitors.

Because of the small size of Airlie Beach, there were no local specialists in the area. Therefore, patients would have to travel to Mackay or Townsville for such services if their condition demanded it. Additionally, some of these specialists would visit Proserpine intermittently, which helped to increase access to health care in this rural area.

Due to the heavy population of tourists and itinerant workers, it meant that they were quite frequently patients too. For example, many people visited in order to obtain a dive medical, which is required for scuba diving. Additionally, there were quite a few patients presenting with acute injuries and conditions. However, as the practice did not bulk bill, it meant that tourists might have chosen to visit another service in town. The island and mainland residents were more likely to see Dr Squires.

A particularly striking feature of the practice was its emphasis on preventative medicine and health promotion. Being a sunny tropical location, an obvious health concern was sunburn and skin cancer. Societal attitudes have meant that a tan remains socially desirable, which was illustrated by the number of people sunbaking at the lagoon. Additionally, as many people worked outdoors and in the tourism industry, they spent a lot of time outside. This was reflected in the nature of quite a number of presenting complaints, which included many skin exams and observing numerous solar keratoses being burnt off. Dr Squires' health promotion also extends to a nearby primary school in Cannonvale. He visits once a year, giving a presentation to a young and eager audience, whose artwork covers the walls of his consulting room. Also, the surgery contains many educational pamphlets, covering numerous topics.

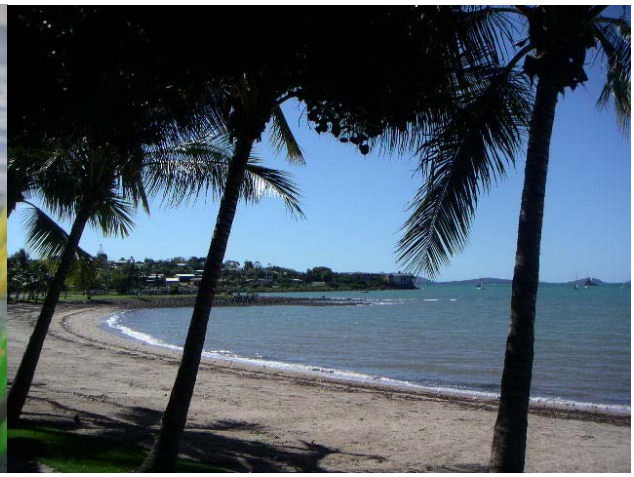
Blessed with a tropical climate, boasting average temperatures around 30°C, it is not surprising that tourism is its major industry. Unfortunately, due to the jellyfish during the period outside of May to October, we couldn't swim at the beach to cool off. With the town on the edge of the photographic Great Barrier Reef, we discovered its wonders during our spare time. We were able to snorkel and scuba dive Hardy Reef, an outer reef two hours from Airlie Beach. This was finished off with a yummy seafood buffet lunch.

(continued on the next page)

We were also able to spend a day with the ambulance service in the neighbouring town of Cannonvale. They were very willing to show us around, including giving us a very comprehensive tour of the two ambulance vehicles. It was a pretty quiet day at the service, however we did drive a person to Proserpine Hospital, which is about 25km from Airlie Beach. While we were there, we were able to learn a bit about the hospital and the town. The hospital is quite new, and has less than 40 beds. Proserpine itself was markedly different from Airlie Beach, and is a rural centre with a history embedded in cane and cattle farming.

Another place we visited was the community health centre in Cannonvale. We attended their weekly meeting, and were given a description of what everyone did. Some of the many services offered include growth and development assessments, advice and support for families, the aged, disabled and carers, mental health assessment, counselling and education, drug and alcohol counselling and support, as well as a methadone program. We actually sat in on some of the methadone program consultations, which was particularly interesting. In the future, I hope to spend more time at the community health centre and get involved with their other services.

I had a wonderful time, both in and out of the surgery, with everyone being very friendly and down to earth. On subsequent placements, it will be great to see how the community and the practice both change over time. I am also looking forward to developing my clinical skills through my placements as I progress through medicine.

RAMUS scholars Julie Chan and Jock Simpson take some time off to enjoy the beach.

What is This Thing Called "Rural Medicine"?

Sonia Purcell
MBBS 3 – Australian National University

In Goulburn the sun was shining and a gentle breeze was blowing as 22 fresh faced second-year medical students from the Australian National University (ANU) approached their different rural week excursions with enthusiasm. For my part, I stood, beside six other medical students, precariously balancing on one green gumbooted foot wondering: "How exactly does an abattoir relate to 'Rural Medicine'?"

Hosing the sole of the other gumboot and most of my leg I began to reevaluate my ideas and distracted myself from my soggy reality by pondering: "What was 'Rural Medicine' really about? Was it somehow more than the sum of its parts? More than the practicing of medicine in a rural environment? Was there more to 'Rural Medicine' then meets the eyes?'

(continued on the next page)

Rural Week: Unexpectedly educational

Like most RAMUS scholars I like to think I have a reasonable idea of what is meant by the term 'rural'. Also, like most second-year medical students I pray that the last two years have given me some semblance of an understanding of what is meant by 'medicine'. However, as I learnt on rural week, a combined understanding of what is meant by 'rural' and 'medicine' is barely enough to scratch the surface of what is meant by 'rural medicine'.

For me, and 22 other students from the ANU, Rural Week took place in Goulburn. The closeness of Goulburn to my hometown of Bowral (approximately 60km) meant that heading out to spending a week on rural experience felt somewhat like heading home.

The trip to Goulburn was, however, an educational excursion and as such was packed full of official and unofficial educational experiences from day one. From the bus tour of Goulburn and the meet and greet with local doctors on the first night right through to the farewell to Goulburn dinner and mechanical bull riding at the local RSL, there were lessons to be learnt. However, the greatest insights I gained from Rural Week was that the complexity of 'rural medicine' is often underestimated (even by those of us who have a rural background, i.e. Me!) and that the rewards you can get from practising 'rural medicine' are soundly based on your openness to new experiences and your willingness to put a little work in and have a go.

The rural experiences that we undertook in Goulburn were based around the ANU's rural health mission: 'To deliver excellent medical education which will contribute to a sustainable, accessible and well-trained medical workforce for the region'.

Goulburn Rural Experience 2005	ANU's rural 'Key Result Areas'	Unofficial Learning Objective
Meet and Greet Dinner	Gain exposure to rural health community experiences and issues.	Meet interesting rural doctors and be inspired.
Tour the hospital and associated health infrastructure	Develop an understanding of how community and support networks operate in rural towns.	Appreciate that even Centrelink is nicer in rural areas.
Clinical visits and patient interviews	Develop effective communication skills with a range of people within the rural practice setting. Exposure of medical students to quality rural medicine.	Catch up on local gossip and answer lots of questions about being a medical student.
Tour of Crookwell/ abattoir/ cancer clinic	Facilitate the development of empathic and active listening skills and reflective thinking. Increase awareness of the cultural, socioeconomic and occupational issues that impact on the health of particular groups in rural communities.	Get out and about in the community and do some sight seeing. Appreciate the diversity of health issues in rural medicine.
BP screen in the Mall	Provide opportunities for medical students to make a contribution to the life of the rural community.	Check out the shopping and refuel on non-instant coffee.
Riding the Mechanical Bull and Karaoke at Goulburn RSL	Immersion of students in rural lifestyle.	Gain first-hand experience with soft tissue damage and provide opportunities for embarrassing photos (not included).

(continued on the next page)


(l) ANU students take a break from all the fresh air to get some study.
(r) Front row from left: Dr Steve Myers, Sonia Purcell, Rosalyn Hunt and Imbi Ehvart. Back row from left: Lisa Ho, Jeff Van Gangelen, James Miller and Travis Brown scrub in at the abattoir.

Lessons from the abattoir

Back to that question… How exactly does an abattoir relate to rural medicine?
Short answer: Good comparative anatomy revision!
Long answer: The abattoir allows for investigation into many areas of rural medicine. These include workplace health issues (OH&S, safety and prevention, stress, job security issues in industry and agricultural based rural locations), infection control and agriculture (vaccinations, Q-fever awareness and work practices to prevent cyst- and prion-infected meat products getting onto the market), social issues (hierarchy at work and access to further education and training and other employment opportunities in rural locations), cultural issues (Halal slaughtering and working with a multicultural workforce), and much more.

RAMUS Support Team Update

Welcome to **Peter Brown** joining us as the RAMUS Alumnus Project Officer and many thanks to **Himali** who has handed over the Alumnus network to him and who also assisted greatly in the last few months with this year's application round. Our best wishes to her as she starts a new degree at University of Canberra. She will be continuing her involvement with RAMUS while working with us one day a week.

Peter has joined the RAMUS team to help develop alumnus services. He will be working on a major project, to be developed over the next year, tracking RAMUS scholars' career paths.

Peter has recently worked in various roles in the office of the National Rural Health Alliance. He was part of the organising team for the 8th National Rural Health Conference held in Alice Springs in 2005. He has also had several assignments with Services for Australian Rural and Remote Allied Health (SARRAH) helping to establish its post-graduate scholarship scheme and consolidate its new national office operations co-located with NRHA in Canberra.

Peter worked previously for the Commonwealth government in a range of positions including the National Council for the Centenary of Federation, managing its History and Education Program and its international liaison. Prior to this he was Cultural Counsellor in the Australian Embassy, Beijing for a five-year posting. He enjoys cycling and yoga.

All others are continuing as your support team. **Janine** has recently been away from her farm on a very enjoyable visit to Toowoomba. **Denisse** will be travelling around the world for two months from mid-May visiting family, friends and new horizons. **Margaret** is imagining rural and remote visits, dreaming about different trips and other possibilities.