



July 2007 Edition - a newsletter for RAMUS Scholars, Mentors and Alumnus members

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The opinions expressed in *Gone Fishin'* are those of the contributors and not necessarily of the National Rural Health Alliance or its individual Member Bodies.

From the RAMUS team

We welcome 153 new RAMUS scholars in 2007. Our new scholars are from 16 universities, including for the first time the University of Wollongong and University of Western Sydney, both of which had their first intake of medical students in 2007.

We also welcome more than 70 new RAMUS mentors. We are currently contacting the new mentors and sending each of them an information package about RAMUS and the mentoring program.

Contributions from current and former RAMUS scholars in this issue include Melanie Johnson's report on her elective in Kenya and Anna Holwell's article on volunteering in Tibet with the Australian Youth Ambassadors for Development program. Donnetta Charles writes from South-West WA about her life as a GP registrar working with her former RAMUS mentor. Jake Parker and Christopher McAulay-Powell report on conferences they attended with support from the RAMUS Conference Placement Program.

National Rural Health Alliance Executive Director, Gordon Gregory, outlines the NRHA's response to the Federal government's intervention plan for Indigenous communities in the NT. Other articles cover how to get published, and a report on a study of palliative care for rural Aboriginal people published in the latest *Australian journal of rural health (AJRH)*. RAMUS scholars have free access to *AJRH* online.

Thank you to scholars who have submitted their learning plan for 2007. For continuing scholars these were due on 1 June and for new scholars they were due within two months of accepting a full scholarship. Carol and Janine from the RAMUS team are currently contacting scholars who have not yet submitted learning plans. Please remember that you risk having your scholarship payments suspended if you do not provide the documents required by the due date.

Over the past few months, several RAMUS scholars have called in to our office in Canberra. We really enjoy meeting scholars and mentors face-to-face, so if you are in Canberra please visit us at the National Rural Health Alliance, 10-12 Campion Street, Deakin, Monday – Friday, 9am - 5pm.

Susan, Carol, Janine and Peter
The RAMUS team

Life as a rural GP registrar

by **Donnetta Charles**

They were spot on when they said it will go quickly, much more quickly than I thought six years would go. Before I knew it, I was finally above the student poverty line and facing a whole new set of professional challenges. My wedding day jitters paled in comparison to the anxiety caused by my first few working weeks. (Ask any doctor regardless of age and I'm sure they could recount vividly those first few evenings on call). Yet in retrospect, those three hospital years were integral to my professional development and I'm glad I chose to work a little longer as a hospital resident before venturing out into GP land. For aside from the obvious benefits of networking and gaining an appreciation of a variety of specialties, those years as a resident gave me time to grow into my own expectations of who a doctor should be. So by the time I moved into General Practice (despite the numerous 'you look far too young to be a doctor' comments), the transition was far from onerous. Plus, it gave me time to publish a few papers and arrive at the conclusion that research is still one of the steepest learning curves I've ever encountered!

One point I've come to appreciate, thanks to RAMUS, is that when stepping into the rather large shoes of a rural GP, it helps to know someone who wears them well. That person is my mentor Dr Mostyn Hamdorf who, I'm proud to say, recently received the RAMUS Mentor Award for 2006. Aside from his professional advice and support, Mostyn remains an inspiration to many as one of Dunsborough's most loved GPs. He manages to strike that elusive work/life balance (more often than not), whilst still giving so much of himself to both his practice and other community based projects. How anyone could function so capably under the spotlight of a small town gave me the determination to rise up and do the same. So my husband and I packed up and came home to the South West of Western Australia, leaving behind the comfort of my fairly anonymous role of metropolitan hospital life to come live amongst my patients.

Certainly, working as a GP registrar has added a richness and complexity to my practice of medicine that I've really come to enjoy. Aside from the sheer bliss of near normal working hours and my own consulting room, the enjoyment one receives from the continuity of patient care cannot be overstated. It has also been quite a humbling process, particularly when I was forced to re-read the best treatment for the same ear infections I'd so flippantly 'referred back to the GP' from the emergency department. Plus, just when you think you had seen it all in hospital, each day someone walks through your door with a new lesson and a new story. I guess it is just as well we never stop learning as we really can't afford to!



**Donnetta Charles and her husband
Paul**

So I've come full circle; the checkout chick from the small country town returns from the big smoke as local GP registrar. Many things have changed in my home town but the good natured country spirit remains. It still amazes me that complete strangers nod hello to you as you walk by. I remember I did the same when I first moved to Perth only to see many a shocked face (looking much the same as my unaccustomed reaction these days I'd imagine). It's one of the many aspects of rural living I failed to appreciate until I moved home and there are certainly many more encouraging reasons to stay. Fortunately my husband has been able to find work in his area of expertise in the area and our family has been more than supportive in our transition, so it seems that this may well be our last port of call (at least for a while).

To be honest, it only just occurred to me whilst writing this piece that I've finally achieved what I set out to do all those years ago as a high school student. But then again, how could I fail? I had the support of so many motivated and inspirational individuals like my local mentor, groups within my university and organisations such as RAMUS. With their guidance, I was so confident I

could achieve my goals that I never stopped to consider my rural background as a disadvantage. In fact, it just made me strive harder. Which is just as well, for the view is beautiful from here.

Conference reports

Reports from RAMUS Scholars about their experiences at recent conferences show the diversity of opportunity available under the program. **Christopher McAulay-Powell** reports on his impressions of Shifting Sands, the conference of the Rural Doctors Association of Queensland. **Jake Parker** found the AMSA Developing Worlds conference a stimulating experience

Shifting Sands...Changing Tides: the next generation **Rural Doctors Association of Qld 18th Annual Conference** **by Christopher McAulay-Powell**

Emergency medicine workshop:

I found this workshop very useful and educational as the main themes were:

1. Airway management – basic airway manoeuvres to more advanced airway management
2. Resuscitation – updating CPR and defibrillation skills with new ARC guidelines.
3. Case studies – common and important emergency presentations.

The main aim was to give rural practitioners a chance to brush up on emergency practical skills they may not have used for a while. We also discussed case studies that brought out the salient points of common and important medical conditions. What I found very useful was the discussion of recent changes in management guidelines of various medical conditions such as myocardial infarct and arrest management. It was interesting to learn the vast differences in the management of emergencies between urban and rural centres. We discussed many key issues that surround the rural emergency such as logistics, how to deal with lack of equipment and resources, transportation, transfers to tertiary centres, improvisation, and who to ring for advice. The main message I got from that session was whilst rural emergencies are daunting, there is always someone to call for help and you must be comfortable with your own limits.

Musculoskeletal workshop

This day revolved around the history, examination, investigation, anatomy, diagnosis and management of back pain. This is a very common problem and this session cleared up many issues that I had with understanding back pain. It again involved case study discussion and revealed common diagnostic patterns. We were taught many massage and manipulative techniques and were able to practise these on each other. We were also taught injection techniques used to treat chronic back pain.

Rural medicine politics and understanding ‘Generation Y’

The session titled ‘Young Bloods: solutions for the future of rural practice’ discussed the gap between young doctors and a career in rural medicine. What are the obstacles, what does this next generation want, what do we need to change in order to attract more graduates towards a rural career? There were many opinions and speakers ranging from state politicians to rural doctors. There was a broad overview of the issues that surround QLD health, work trends, and job opportunities and how they interplay with the new workforce.

The keynote speaker was very entertaining and attempted to bridge the gap between the old and new generations. The main point was to give rural doctors, health providers and policy makers tips on how to connect and understand the next generation. There was much emphasis on what needs to change in order to best attract and keep young doctors. The take home

message was that times have changed and changes need to be made in order to make rural medicine attractive to Generation Y.

The medico legal forum brought forward many issues that surround rural medicine. It was an opportunity for politicians, doctors and students to voice current opinions in rural health. Such issues were: Universal Service Obligation; Rural Maternity Services; Rural VMO Awards; Safe Working Hours; and New Workforce Models. I found this session worrying at first because it mainly focused on the negatives of rural medicine and what was wrong with the system. I was exposed to aspects of this career that really don't make it attractive. However, the fact that there is an environment of change and things are looking better is comforting.

Heart failure workshop

This workshop used case studies to discuss history, examination, investigation and management of heart failure. It again was to update rural practitioners on the new guidelines in managing CCF and its complications. Issues discussed were: disease management programs in the community; diastolic heart failure; cardiac resynchronization therapy; obesity, alcohol, and sleep-disordered breathing cardiomyopathy; beta blockers in COPD patients; and BNP.

The conference covered many topics that are key to a career in rural medicine. It was good to discuss how rurality impacts on managing common and important medical conditions. I enhanced my practical skills and sharpened my theoretical knowledge. I learnt about 'What one must know to survive in rural practice'. I also gained insight into rural medicine by being exposed to the negatives and positives of choosing a rural career. I would rather be prepared than to be surprised about what awaits. It is comforting to know that people of power are listening and the times are changing.

AMSA Developing World Conference 2007 Conference by Jake Parker

With a background including being a 'kid from the country', a RAMUS scholarship holder and a global and rural health enthusiast, all of my interests seemed to be covered by one conference, the Developing World Conference (DWC). Convened by the Australian Medical Students' Association (AMSA), this year it was held in Adelaide between June 29 and July 1 preceding the more well known and somewhat different AMSA Convention. This year the DWC was themed 'Pathways to Empowerment', and was a hive of medical students bursting at the seams with energy and ideas of how to become more involved in developing world and global health. As some students might be under the impression that a conference on global health would exclude health concerns within a first-world country such as Australia, it is worth clarifying that the term 'global health' incorporates all issues that affect the health of any community in the world. Furthermore, the common referral to Indigenous health as



the 'third-world in the first-world' (or the 'fourth world' phenomenon), validates its inclusion in the term 'developing world'. With such a serious global health issue so close to home, it was no surprise that Indigenous health was a significant topic during the DWC.

The academic program of the DWC was as outstanding as it was interactive. With lectures, panel discussions, open debates, training, workshops and student presentations, delegates

found the experience informative and thought provoking. Session topics included Aboriginal and Torres Strait Islander health, rural and international medical electives, the role and responsibilities of pharmaceutical companies in health care, access to essential medicines, refugee health, cultural sensitivity in health care, Médecins Sans Frontières (MSF), the effect of Fair trade versus Free trade, the World Health Organisation (WHO) determinants of health, corruption in aid work, health in conflict zones, personal security for aid workers, and the relationship between the media and aid work, just to name a few. There were a myriad of local and international speakers who are some of the leaders in their field including Dr Rowan Gillies (International President of MSF) who gave the keynote speech on his experiences as an aid worker and his work within MSF. Other presenters ranged from professors and politicians to doctors and medical students.

In addition to the above academic activities, each delegate was assigned to a case study. I was fortunate enough to be invited to the study titled 'The fourth world phenomenon – the status of Indigenous health in Australia'. During this time, a small group of delegates discussed the wide range of factors that play an integral role in the health outcomes in this population group. Discussion topics included population dynamics, the stolen generation, culture and communication, education and employment, housing conditions, policies regarding drug and alcohol use, access to health care, and cultural awareness in health care. The focus group also explored pathways in which Indigenous health can be managed on a community basis and methods of reducing the burden of disease through public health interventions.



The Developing World Conference also provided a great opportunity to network. I was able to meet other medical students who were interested in rural and Indigenous health from universities across Australia. Within the representation at DWC, there were numerous students holding rural scholarships as well as students that had instigated rural and Indigenous health projects. By the end of the conference, not one delegate was apathetic to the health status of Aboriginal and Torres Strait Islanders, and all delegates left with a greater understanding of the health challenges that they face. I was also able to encounter some of the many organisations involved in rural and Indigenous health. Delegates were able to further explore the opportunities available for students and young doctors in rural and remote medicine. Other organisations introduced delegates to a few of the campaigns that raise awareness of Indigenous health including Oxfam's 'Close the Gap' campaign (www.oxfam.org.au/campaigns/indigenous).

Although I returned from the DWC full of raw enthusiasm and grand ideas of how to change the world, it's easy to lose the good intention in the wind-down. So I remind myself of the ways in which I can make a real difference now and into the future. Staying informed about the global health issues, especially those within Australia, is a good start. Acting as an ambassador for the people with a poor health status by creating discussion and awareness among colleagues, family and friends is an effective action that we can all take. Investing considerable thought into spending a proportion of your professional career treating people with some of the most serious health challenges, such as Indigenous Australians, is essential if you wish to be successful in the endeavour. I encourage everyone to explore the channels in which you can engage global

health as a student, a medical professional and a citizen. Finally, I would implore all students to get involved today. You don't have to be fully qualified to make a difference. I heard a quote by Margaret Mead at the DWC, which I believe sums this up neatly;

'Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.'

In 2008 the Developing World Conference will be held in Melbourne and is taking on the name Global Health Conference. I encourage any student interested in becoming more involved in rural and remote medicine, Indigenous health or any other part of global health to make a resolution to attend. I look forward to meeting you there.

Conference Placement Program

There are plenty of conference opportunities for RAMUS Scholars and former scholars who are Alumnus members included in the list of conferences approved under the RAMUS Conference Placement Program for 2007-08. (The list is up-dated regularly.)

For 2007-08 the grant limits are increased to \$750+ for conferences within 200 kms of your term address and to \$1500 for conferences beyond 200 kms.

Full details and application forms are at
<http://nrha.ruralhealth.org.au/scholarships/?IntContId=77&IntCatId=7>

Don't forget that we will also consider conferences that have not been approved. See the guidelines for how to make a special case.

Photos Wanted



We want photos for Gone Fishin'! To get the ball rolling we are starting off with a theme of **new scholars** in the next issue. So all you new RAMUS scholars out there, next time you are with your mentor, on prac at hospital or on rural placement, get snapping.

Your suggestions for future themes are also very welcome – what photos would you like to see?

Life in Lhasa by Anna Holwell

After six years at university and completing my intern year at St. Vincent's in Melbourne, deciding to take twelve months off to work as a volunteer in Tibet was an easy decision. A twelve month trip to a place I've always dreamt about going to; an opening into a career in international health and development work; a year without discharge summaries and night shifts. It was too good to pass up.

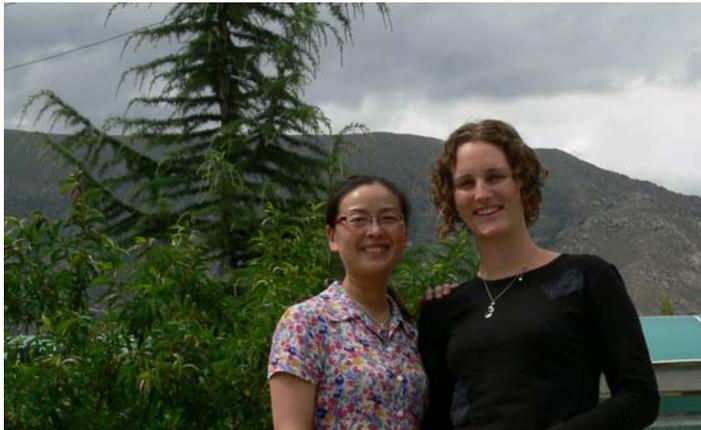


Anna Holwell with Tibetan colleague, Pelky

I am currently a volunteer in the AusAID funded Australian Youth Ambassadors for Development (AYAD) Program.

I'm based in Lhasa, Tibet, and I am three months into a one year placement. I am working with the Tibet Health Sector Support Program (THSSP), which is a primary healthcare project. It is a joint initiative between the Australian Government and the Government of the People's Republic of China, and we work closely with all levels of Health Management. It is jointly managed by the Australian Red Cross and Burnet Institute.

My work is based in the Infectious Hospital of Tibet Autonomous Region, and involves contributing to the development of an improved Infection Control Program, and also HIV diagnosis and management policies and protocols. Both areas have received a lot of attention in China over recent years. My role is to assist my counterparts in developing protocols and work practices in these areas.



Anna Holwell and Dr. Gong Xuehong head of the Infectious Diseases Department at No2 Regional People's Hospital, Lhasa.

To say that arriving in Tibet was a shock to the system would be a rather large understatement. Stepping off the plane I first noticed the bright white light and harsh intensity of the sunlight. With significantly less atmosphere above us, at 3675m above sea level, Tibet's UV rays are around 30-40% stronger than at sea level. My first week in Lhasa was spent dealing with mild altitude sickness symptoms- headaches, dizziness and insomnia- and taking things easy to prevent anything more dangerous.

Oxygen levels in Lhasa are around 30-40% less than that at sea level, so my first month was spent battling breathlessness. Walking on the flat was hard; up three flights to my apartment no small feat... add two bags of shopping and I felt like I'd done my exercise for the week. Luckily my EPO has kicked in and am breathing much easier these days.

Despite the physiological stresses, living in Lhasa is great, and I am looking forward to the rest of my year (even the winter!). Doing some non-clinical work has been a nice change- I'm learning a lot of new skills I wouldn't otherwise have. Instead of looking up a protocol on the computer and following it, I'm now helping to write the protocols. I'm learning why we do things the way we do- whether it be treating a disease or infection control practices- and it's giving me a whole new view of health provision and patient care.

Walking to work along pathways lined with Tibetan spinning prayer wheels is pretty amazing and looking from my office window at a horizon of snow capped mountains all higher than 5000m is - literally - breathtaking.



Anna Holwell with translator, Tsewang

My time in Kenya

by **Melanie Johnson**

This is the 10th time I have sat down to try and write about my elective in Kenya. The experience was so life-changing that I have difficulty believing that it even happened and it has taken me a long time to process all I have seen.

The first question that inevitably gets put to me when I talk about my elective is – Why Kenya? And more particularly, why Nairobi? I can understand their confusion. Why would I choose to fly half way across the world to one of the most dangerous cities to do my elective when so many others were planning holidays on tropical islands and looking forward to a hassle free Christmas? I can tell you that the first time I drove through the slums of Nairobi I was asking myself the same question.

I spent my time at Mbagathi District Hospital, on the cusp of the largest slum in Africa, Kibera. It is a public hospital – but the patients do not get free service, they must pay the equivalent of a day's work to be seen by a doctor in casualty and more if they are admitted. While the hospital had around 300 beds often the number of in-patients doubled this. Two patients per bed, or even three, was not uncommon and it was one of the hardest things to get used to.

I knew I was in for a hard time adjusting but nothing could have prepared me for the conditions experienced in the hospital and in the community. No fly-screens meant the flies and mosquitoes were everywhere. No diagnostic tests meant that if you wanted anything other than a haemoglobin count or a blood smear then you were out of luck. Even after diagnosing the patients, the chance that the hospital would have the drugs to treat them was minimal. I was so used to being in a situation where everything I needed was at hand. In rural Australia physicians face the same problem, although not to the same extent. Just like the doctors in Kenya our rural physicians get used to diagnosing and treating problems with limited resources.



The most vivid memories I have are of my time on the paediatrics ward, where children who weigh less at nine months than at birth were common and diseases such as pneumonia and gastroenteritis became life-threatening situations. It was really hard to go and eat my small lunch when there were children 100 metres away from me dying of malnutrition. While the paediatric ward provided me with some of my sadder memories it also gave me some of the most candid. Children who came in very sick would get better and would reach up to me for the toys or lollies I bought them. Most of them had never received a gift before. It's hard not to smile when you see children playing with little kangaroos and koalas thousands of kilometres from home.

HIV is a big problem in Kenya. Over 60% of the hospital's patients were sero-positive and hundreds of outpatients a day flocked to the hospital for their anti-retrovirals (ARVs). I was very lucky to have the chance to work with a Medicines San Frontier clinic on the grounds of the hospital where they supply thousands of patients with free ARVs. It is very humbling to see the extent of their work and the number of lives they touch.

Reading this it may seem that my days were full of heartbreak and challenges. And to some extent I guess they were - but there were also so many lovely moments as well. When I first arrived I was caught off guard by the patients and staff calling me *Sister*, I thought that they had confused me with a nurse. It was only after a week that I realised they meant it literally. They called me *Sister* because they were inviting me to be a part of their family in a way. The people

of Kenya made me feel welcome from the moment I landed in their country. Despite the hardships that they face it was rare to see them without a smile or polite word to say to me.

I went on elective with the misguided belief that I would be able to change something. My boxes of donations and small money contribution seemed but a drop in the ocean. The problems Africa faces are enormous, both medically and socially. I don't know what the answer is and I'm not sure if there is one. You just have to carry on and hope that whatever small contribution you can make will change things for at least one person. If there is no hope of that then there is no point in trying. A bit of a cliché I know but there really is no other way of putting it.



My elective was challenging, heart wrenching and eye-opening and has made me so grateful for the life that I live. I still complain about exams, about going to the gym, about a one-day wait to see a doctor, about the cost of fuel... but now it all seems a little unimportant in the scheme of things. My time in Kenya has shown me how much can be done with very limited resources and the lessons I learnt will stay with me for my practising life and beyond.

Congratulations Belinda Gowen!

Belinda is a new RAMUS scholar this year and has been awarded one of seven annual NSW Farmers' Association Tertiary Scholarships. Scholarships were awarded on the basis of all round ability, leadership qualities, a commitment to agriculture and academic achievement.

If you have any news that you would like to share, please contact the RAMUS Team at ramus@ruralhealth.org.au or 1800 460 440.

The government's plan for Indigenous communities by Gordon Gregory, Executive Director, NRHA

The National Rural Health Alliance (NRHA), which administers the RAMUS Scheme, is the peak non-government body for rural and remote health in Australia. It is comprised of 27 national organisations, including the National Rural Health Network (of student health clubs).

The NRHA's goal is equal health for people in rural and remote areas by the year 2020. This is an ambitious target, given that people in rural and remote areas have worse health outcomes, experience greater health risk factors (rates of smoking, excessive drinking, risk-taking, self harm), and the cost of delivering any given level of health services is higher due to small populations and large distances.

Given that its core business is health in rural and remote areas, the Alliance has obviously been long concerned about Indigenous health. The National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Indigenous Doctors' Association (AIDA) are both members of the Alliance.

Not surprisingly, the announcement made by the Prime Minister on June 21 was of immediate and vital interest to the Alliance. John Howard's announcement was almost certainly the most important single decision taken for 40 years about Indigenous health and wellbeing in Australia.

The matter is very complex: politically, culturally, clinically and in its practical implications. Nevertheless, most people would agree that there has never before been such an opportunity to find a solution to the challenge which is Indigenous health and well-being. Although the decision was made hastily and without consultation, it has led to the situation in which, for the first time ever, there is bipartisan political support for an ongoing program of action and support, the promise of substantial financial commitment, and widespread public and media attention on it.

The NRHA's view is summarised in the media release reprinted below.

In my view the main challenge is to take the opportunity and to make it work for Indigenous communities in the Northern Territory and, thereafter, elsewhere in more remote parts of Australia.

Health professionals prepare PM for the long haul (NRHA media release, 5 July 2007)

The National Rural Health Alliance (NRHA) has alerted the Prime Minister that it will take a generation or more to eradicate the primary causes of community and family dysfunction in the Northern Territory.

NRHA chairperson Professor John Wakerman also cautioned in a letter to Mr Howard that alleviating core problems will require significant investment in areas not traditionally linked to the health sector.

'These investments in education, housing, employment, water, transport and food will have to be at substantial levels – and ongoing,' he said.

'We hope that such long-term investments in rural, regional and remote areas will be forthcoming. Like the emergency response, the long-term action must be well-resourced and comprehensive.'

'To recruit and retain the numbers of health professionals necessary will require major development of health service infrastructure, establishment of high quality management and governance systems involving communities, and appropriate linkages between key service, training and professional support agencies.'

The NRHA said it understands the Prime Minister's 'significant personal investment' in the recent taskforce initiative, but noted that child abuse is a national problem not confined to Indigenous communities.

'We are pleased to understand that the proposed health checks will relate to general health and wellbeing, not just sexual abuse. In planning for widespread child health checks it is essential to recognise that the children in most Aboriginal families living in the Northern Territory are not in jeopardy,' Professor Wakerman wrote.

The NRHA confirmed support for some of the proposed measures, such as extra policing and reduction of alcohol availability, including in regional centres, but advised these measures should be complemented by a range of proven community-based strategies such as home visiting services by suitably qualified nurses and other professionals.

The purpose of writing to the Prime Minister, with copies to Health Minister Tony Abbott and Indigenous Affairs Minister Mal Brough, was to offer the NRHA's help in meeting the commitment and ensuring the Alliance's concerns were clear about how plans should proceed.

'The government is clearly aware of the critical importance of collaboration with Indigenous leaders and communities, and with other levels of government, to ensure successful longer term outcomes,' said Professor Wakerman.

'We are aware of the refinements to the commitment initially made, and urge your government's early consultation with the Aboriginal Medical Service Alliance Northern Territory (AMSANT), whose advice represents the views of Aboriginal health services providers on the ground.

'For the professional health and community services work proposed, we do not support the use of volunteers who are unfamiliar with working in remote communities. We trust this is not what you have in mind. For people involved with delivering the envisaged services, cultural safety, cultural respect and cultural security frameworks need to be taken seriously.'

Professor Wakerman said Aboriginal Health Workers play a key role in improving health outcomes in their communities and that further development and support for the profession would enhance the chances of long-term success.

The NRHA represents 27 national organisations, including consumers and providers of health services in rural and remote areas. Among these are the Australian Indigenous Doctors Association, the National Aboriginal Community Controlled Health Organisation and the Royal Flying Doctor Service.

Writing for publication – a new resource on how to get published

Have you ever wanted to get an article published in a refereed journal and wondered what the trick is? If so, there is useful information and support for you on the National Rural Health Alliance website and on a new CD ROM from the NRHA.

The material is from a *Writing for Publication* Seminar held by the Australian Journal of Rural Health in conjunction with the 9th National Rural Health Conference in Albury in March. You can listen to the audio stream of the papers or read the transcripts.

Topics covered include the principles of good writing; preparing a scientific paper; specific tips for getting published in the *Australian Journal of Rural Health*; and how on-line submission of manuscripts works for authors and referees.

The seminar presentations are by James Dunbar, Editor of the AJRH; Prasuna Reddy, Assistant Editor; Vanessa Farrant from Blackwell Publishing Asia; and Denis Muller.

Denis Muller had a 27-year career in journalism, nearly all of it at *The Sydney Morning Herald* and *The Age*. He was Chief Sub-editor, News Editor and Assistant Editor of the *Herald* and Associate Editor of *The Age*. Hear Denis talk about simple writing - at <http://nrha.ruralhealth.org.au/ajrh/?IntContId=170&IntCatId=20>

Australian Journal of Rural Health

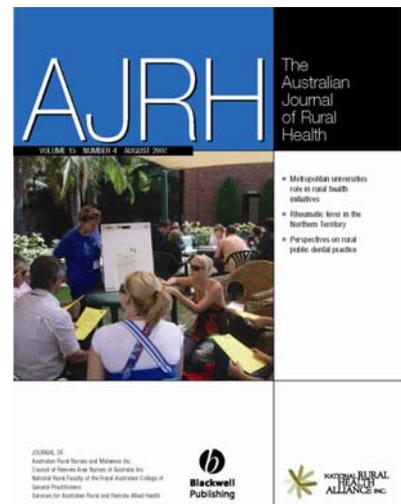
Volume 15 No 4 has just been published and features a new study which demonstrates a strong desire of rural Aboriginal people to die at home. This being the case, it is essential to develop local health care and palliative care services.

Dr Pam McGrath is author of 'I don't want that big city; this is my country here': Research findings on Aboriginal people's preference to die at home'. Her study documents the importance of place of death for rural Aboriginal people and finds that strong cultural reasons drive the desire to pass away at home. Reasons include Aboriginal people's strong connection to their land and community, their belief in 'death country', the importance of being in the right place to pass on sacred knowledge to the appropriate family members, the significance of the right person according to kinship rules being available to care for the dying, and the fear and stress associated with relocation to metropolitan hospitals.

"In view of the findings, it is important to both support and build up local health and supportive services in rural and remote areas, instead of adding distress to the Aboriginal patients by moving them," McGrath says.

"I hope that the insights provided from Aboriginal people themselves, and the health professionals who care for them, will encourage the provision of appropriate health and palliative care services," says McGrath.

This paper is a report from one part of a major national study, funded by the National Health and Medical Research Council, which developed a model for palliative care service delivery for Aboriginal peoples.



RAMUS scholars have free online access to the *Australian Journal of Rural Health* (AJRH). Access is through the RAMUS website:
<http://nrha.ruralhealth.org.au/scholarships/?IntContId=74&IntCatId=7>

Making the most of your rural placements – the NRHN's new guide

The National Rural Health Network (NRHN) has published a guide for students in medicine and other health disciplines to help them get the most out of their rural placements. The guide is full of tips to help you prepare and organise your rural placement. It also covers cultural awareness, keeping safe, managing disclosures and what to do if things go wrong. There is a handy 'essential placement checklist'. *Rural placements guide: how to make the most of your rural placement* can be downloaded from the NRHN web site (<http://www.nrhn.org/>). To have a copy mailed to you, contact the NRHN on 03 8825 4500 or email info@nrhn.org.au

2008 scholarships

While applications for the Rural Allied Health Undergraduate Scholarship (RAHUS) for 2008 have opened earlier this year than in previous years, the schedule for 2008 applications for **RAMUS** has **not** changed.

Applications are now open for 2008 for the RAHUS (allied health) Scheme and will close on 31 August 2007. RAHUS is open to individuals with a rural background studying an allied health or oral health degree.

Applications for **2008 RAMUS** scholarships will open in early November 2007 and close in mid-January 2008.

As in previous years, the RAMUS scholarship application form and guidelines will be available online at <http://ruralhealth.org.au> and information will be sent to the universities, rural health clubs and rural health organisations when applications open. The 2008 RAMUS application round will also be advertised in the national press.

If you know of friends, family members or fellow students who may be interested in applying for RAMUS in 2008, please encourage them to check the RAMUS website or to contact the RAMUS team for more information.

RAMUS Payment Dates

This is just a friendly reminder of the RAMUS payment dates:

Scholars are paid twice monthly, on the 6th and the 21st of the month. The payments are processed 2 business days before the payment date to ensure that the money is in your bank accounts by the 6th and 21st.

Scholars in undergraduate courses are paid from March to December. Each payment is \$500.

Scholars in graduate entry courses are paid from January to December. The first payment in January is \$800 and each payment thereafter is \$400.

The scholarship payments are exempt from income tax under the *Income Tax Assessment Act, 1997*.

Keep your contact details up-to-date

Have you recently moved house? Or changed your email address? Anytime your contact details change, please call RAMUS on 1800 460 440 or email ramus@ruralhealth.org.au so we can update your details on our database.



RAMUS is an Australian Government initiative