opportunities
as vast as the landscape
working in rural and remote health
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One of the more satisfying parts of my job as Minister for Health involves travelling to rural and remote areas and meeting the remarkable Australians who live there. In spite of the very real difficulties facing country people, they invariably tell me how they wouldn’t live anywhere else.

Whether it’s in a large country town, a tiny outback settlement or one of the many hundreds of places in-between, country Australia exerts a strong pull on its people.

My visits to rural Australia often involve the development of new health facilities and services and this gives me particular pleasure. The Commonwealth Government has worked hard to strengthen health infrastructure that exists in rural and remote areas. A particular achievement has been the development of rural clinical schools and university departments of rural health.

There are 14 rural clinical schools across Australia which offer extended medical training to students. This training is equal to that offered to students at city-based medical schools. When offered in the country, though, this experience can provide students with an insight into the practice of rural medicine and a taste of the country lifestyle.

There are 11 university departments of rural health across Australia and these provide medical, nursing and allied health students with the opportunity to develop their skills in a rural area. Again, students can appreciate the special role that health professionals play in a country areas and how attractive a career in rural Australia might be. Rural clinical schools and university departments of rural health also provide practising rural health professionals with the opportunity to provide training to students and to conduct rural health research.

Rural clinical schools and university departments of rural health have become part of the fabric of their local communities. They are improving the lives of country people by improving their access to health services.

Rural clinical school and university department of rural health staff love their work. They care deeply about their students and the communities they serve. Rural doctors, nurses and allied health professionals are passionate about their work and their commitment to their communities. I’m grateful to the people who appear in this book, and their colleagues, and hope other health professionals might join them in their valuable work.

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Australian Commonwealth Minister for Health
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I am a solo rural medical practitioner in Quorn, a picturesque town in the Flinders Ranges in outback South Australia. I have been in solo rural practice for 15 years. I come from a rural background and returned to school when I was 25 years old, as a mature aged student. I undertook medicine with the sole intention of coming back to rural Australia to practice medicine. Subsequently, all my postgraduate training was aimed at being able to provide comprehensive medical care in my chosen community. I have post-graduate training and am privileged in surgery, anaesthesia, obstetrics, as well as general medicine.

While solo practice in rural Australia can be difficult, particularly the constant on-call work, the rewards of cradle-to-grave medicine and the comprehensive care this entails is what makes rural medicine attractive to me. Maintaining my skills in the broad spectrum of procedural medicine is not easy, but it adds a significant and satisfying dimension to the practice of medicine. In some ways I could appear an anachronism, for this I make no apology because it has enabled me to practice comprehensive care to my community. In addition, I have a long-term commitment to succession planning and encouraging medical students and postgraduate colleagues into a career in rural medicine. To this end I have had medical students in my practice for a number of years, and I am also involved in the annual immersion experience in rural medicine for undergraduates of the rural clubs of South Australia’s two medical schools. Because of my advocacy for rural medicine, I am often called upon to speak and to be involved in postgraduate training and undergraduate educational experiences. I have been involved with Flinders University Medical School, Adelaide University Department of Rural Health and Rural Clinical School based at Whyalla in South Australia. It is clear to me and other rural medical practitioners that undergraduate medical education will continue to expand in rural South Australia because that clinical exposure and experience is probably better than is to be obtained in urban centres.

In 2005, I was named inaugural ‘Rural Doctor of the Year’ by the Rural Doctors Association of Australia, not because I am outstanding, but rather because I represent a commitment to rural medicine, undergraduate and postgraduate training, and provide a comprehensive model of care to my community. Indeed, most rural doctors would aspire to the same.
The job is all about the road, the people...

The job is all about the road, the people, the variety, lots of unique experiences and the close relevance of academia to public health practice. As a public health academic with my practice background in community health nursing, I get all these things working in a university department of rural health (UDRH).

For 5 years, I was the Director of Public Health Research at the first South Australian UDRH between 1998 and 2003. During this time, my research assistant Jane Edwards and I formed a close working relationship in applied research with the mental health program in the vast remote landscape of far northern South Australia. This work took us to fantastic places like the opal-mining town of Andamooka, where people do literally live in holes in the ground. With laptop, audio recorder, the four-wheel drive, and after many rounds of consultation we wrote the mental health plan that is now used for the region. For our academic credit we published five articles from this work. Late in 2004 I took up a second UDRH post as an associate professor working in the Northern Rivers Region of NSW. I am still conducting rural mental health service research and recently completed a most rewarding project that examined the processes by which an Aboriginal health service linked with a mainstream mental health team. This work was published in the Medical Journal of Australia. I am currently developing new rural health education programs for the UDRH, such as a problem-based rural public health intensive with the North Coast Public Health Unit for the NSW Public Health Officer Trainee Program. So you can see, for a nurse who really did not like the constraints of nursing in a hospital, and for an academic who does not like to be too far away from practice, rural health has provided me with a productive university career and lots of travel and experiences that I would not get in a city department, such as hosting the Federal Minister for Health when he rode into town on his bike to open our new student housing.
Siaw-Teng Liaw
General Practitioner,
Chair of Rural Health,
University of Melbourne
Head, University Dept.
of Rural Health,
Shepparton VIC

“On Flinders Island I learnt to take and develop x-rays, manage infarcts, catch mutton birds and spear flounder in the Tasman Sea.”

How to sleep in a Landcruiser despite howling dogs

It is not surprising that a medical student during the heady days of the Vietnam War would develop an interest in third world and rural development activities. The altruistic 1970s influenced my choice of student electives. On Flinders Island I learnt to take and develop x-rays, manage infarcts, catch mutton birds and spear flounder in the Tasman Sea.

In the Kimberleys, Western Australia, I learnt about remote and Aboriginal health, how to sleep in a Landcruiser despite howling dogs outside in the Mowanjum Aboriginal settlement, and to catch crabs on the Derby mud flats. In the freezing winter of Fort St John, Canada, I learnt about Native Canadian health and cross-country skiing. While completing postgraduate training in Obstetrics and Anaesthetics in New Zealand, I learnt about Maori health. The point of all this rambling is that medical student placements do influence where doctors choose to practice, especially if their background is rural. I subsequently settled in a three-man general practice in Barmera, a fruit growing and wine-making area in the Murray Valley in the Riverland, South Australia. We did everything from counseling to Caesarian sections to managing a 40-bed hospital. Despite the wonderful environment and lifestyle in Barmera, my wife Gladys needed a sufficiently challenging career – she had a MBA and financial qualifications. After 6 years we left Barmera for positions at Flinders University – Gladys in accounting and me in primary health care. I had become a ‘lapsed rural doctor’ for stereotypical reasons! We completed our PhDs and traveled overseas. I joined Melbourne University’s Department of General Practice in 1994. In 2003, I accepted the Melbourne University Chair of Rural Health and returned to regional and rural Australia to direct the Shepparton University Department of Rural Health program. My vision is a Rural Health Academic Network (RHAN) underpinned by an innovative eHealth, eResearch and eLearning program to improve the academic base of rural health, and to provide a supportive academic environment, with attractive career pathways to encourage health professionals to live and work in rural Australia. The RHAN will link and integrate the urban, regional and rural environments and allow health professionals to move seamlessly and to support one another in a collegial network. Rural health professionals and their partners should be able to move easily in and out of the rural environment for professional and personal reasons, like I did.
In 2003, together we delivered an Aboriginal Health Worker Training Program in order that people could receive recognized training locally. Seventeen Aboriginal health workers graduated and all got jobs, a fantastic outcome from this partnership.

In 2004 the Combined Universities Centre for Rural Health worked with us to evaluate a 0–5 Early Intervention Program. Their support and mentoring was invaluable in documenting the lessons learnt from this program. I love talking to the students about the opportunities and autonomy that remote practice offers me. I believe that the experience we offer allied health and nursing students provides them with a unique opportunity. All the staff here love being part of the week-long rural experience for final year allied health students called ‘country week’, and they also contribute regularly to the first year medical and dental students’ ‘rural week’. I believe my staff and I provide the real stories that students remember when they return to Perth. But working here is hard and I often feel very alone and wonder if I am the only person working in a particular way. The Combined Universities Centre for Rural Health has given me a level of professional support and has validated my practice. This has given me the strength to keep going when sometimes I feel I have been left out in the universe and start to doubt what I am doing. I do feel that people in remote areas feel disenfranchised and do not have a voice. By being a qualified professional in their town you become their voice. If you can get the support of a tertiary organization like the Combined Universities Centre for Rural Health, that voice can become stronger and can keep remote people visible. We need each other to survive and I think we have the same ideals and goals for the rural communities we love and work in.

“\textbf{I love talking to the students about the opportunities and autonomy that remote practice offers me.}”

Helen Webb
District Manager,
Murchison WA
Country Health Service,
Midwest Murchison
Region WA

You be\textbf{come their voice}

Well I guess the relationship with the Combined Universities Centre for Rural Health started in 2000 when the general manager did a fellowship with them to develop a primary health model of care for our community. I joined the service in 2001 and became the district manager in 2003. Since then the relationship has strengthened.

In 2003, together we delivered an Aboriginal Health Worker Training Program in order that people could receive recognized training locally. Seventeen Aboriginal health workers graduated and all got jobs, a fantastic outcome from this partnership. In 2004 the Combined Universities Centre for Rural Health worked with us to evaluate a 0–5 Early Intervention Program. Their support and mentoring was invaluable in documenting the lessons learnt from this program. I love talking to the students about the opportunities and autonomy that remote practice offers me. I believe that the experience we offer allied health and nursing students provides them with a unique opportunity. All the staff here

love being part of the week-long rural experience for final year allied health students called ‘country week’, and they also contribute regularly to the first year medical and dental students’ ‘rural week’. I believe my staff and I provide the real stories that students remember when they return to Perth. But working here is hard and I often feel very alone and wonder if I am the only person working in a particular way. The Combined Universities Centre for Rural Health has given me a level of professional support and has validated my practice. This has given me the strength to keep going when sometimes I feel I have been left out in the universe and start to doubt what I am doing. I do feel that people in remote areas feel disenfranchised and do not have a voice. By being a qualified professional in their town you become their voice. If you can get the support of a tertiary organization like the Combined Universities Centre for Rural Health, that voice can become stronger and can keep remote people visible. We need each other to survive and I think we have the same ideals and goals for the rural communities we love and work in.
My present position combines all the elements I love: cultural diversity, gutsy people, teaching, creativity and endless possibility.

Marisa Gilles
Senior Lecturer,
Combined Universities Centre for Rural Health,
Carnarvon WA

I love adventures

Born in the United Kingdom and brought up in Nigeria until I was six, I love adventures. I left home when I was 18 and have lived and worked in many countries. I fell in love with central Australia when I arrived in Alice Springs for 3 months in 1989. I stayed 4 years. My love of Aboriginal health and culture stems from this time and I have been involved with Aboriginal health ever since. In 1998 I was invited to Canarvon to be the director of the public and community health unit. This was the most exciting, challenging and formative job I have ever done. But working in remote areas is hard, and in 2002 I was burnt out. My life has always been punctuated with working at the coal face and then returning to study. When I was offered a fellowship at the Combined Universities Centre for Rural Health, it was like an oasis in the desert. When a position came up to work there I jumped at the chance. Working here has given me the freedom to follow my dreams. I have an interest in the link between the arts and health, and dancing is a vital part of my life. So when in 2004, my friend obtained a Healthway grant to carry out a five and a half week tour of the Midwest and Gascoyne I joined her for 2 weeks, supported by my university. As I negotiated the muddy road out to Wiluna and shared unique moments with over 700 women and children I reflected on how lucky I was. My work involves a weekly clinic at the local prison. The public health potential of good prison health is another passion of mine. When I came here I had two main aims: to develop a mechanism to measure community strength and follow its progress in Carnarvon over the next 10 years and, to make sure that other colleagues at the coal face could also have some thinking time. Three years later I think I am achieving those aims and creating more. For once I am not ready to move on but I am excited about what the next 10 years has to offer. My present position combines all the elements I love: cultural diversity, gutsy people, teaching, creativity and endless possibility.
“When I realised there might be an opportunity for me to work here and do research I practically begged to join.”

Frances Boreland  
Research Officer,  
PHC-RED Program,  
Broken Hill UDRH NSW

Sometimes you get lucky

I trained as a field ecologist and still see myself as that, only now instead of studying the interactions between plants and animals and their physical environment, I’m studying the interactions between people and their social and physical environment. The species isn’t as cute, the day-to-day work doesn’t generate as many interesting anecdotes (crawling down wombat warrens has a certain cachet that developing a good questionnaire just can’t match), but the questions are as interesting and important. I came to Broken Hill 16 years ago to work on a project with NSW Agriculture.

If you had told me then that I’d change what I do to stay here, I wouldn’t have believed you. I was passionate about my work. But people can change in surprising ways, and Broken Hill caught me when I wasn’t looking. After a few months I realised that, against all expectations, I’d found the home that I’d been missing for a long time. You don’t get that lucky twice, so it was easy to decide to do whatever would let me stay. There was little funding for ecological research at the time. A couple of years after my initial contract ended I began working with the Broken Hill Lead Management Program, and became involved in research on lead levels in and around homes in Broken Hill. I came to know of David Lyle and the Broken Hill University Department of Rural Health when I was looking for help with the research analysis and writing up, and gradually became aware that David had been trying to build up a research team for some time. He was finding it difficult to get experienced people to come, or less experienced people to stay and develop their skills. When I realised there might be an opportunity for me to work here and do research I practically begged to join. It is a delight to work in an environment with such a positive emphasis on upgrading skills. Since joining the department in 2001 I’ve completed a Graduate Certificate in Population Health Research Methods, am completing a Master in Public Health this year and beginning a PhD next year. I hope to work here for a long time to come, and give back to the department for making it possible for me to live in Broken Hill and do research. I did get that lucky twice!
In 5th year I spent two vacation weeks at Glen Innes hospital and with a GP there – not a common event in those days – but it strengthened my interest in rural general practice. Two years as resident medical officer followed, averaging 80 hours/week, then one at Royal Alexandra Hospital for Children, where Anne, my wife had trained as a nurse, then a year as paediatric registrar at St George. My closest friends date from those busy days. 1971 began with 6 months in Young as GP assistant, then to UK for 2 years to ‘practice anaesthetics and obstetrics on the poms’. By now we had Elisabeth and Michael, and David was born in Birmingham. Returning home, we went to Cooma for a 3 month locum, but fate stepped in. On the third day, a bus rolled down a mountainside, killing 19 people and injuring 20. The response of practice, hospital and townspeople so impressed us that we stayed for 23 years. So life might have continued until retirement – but Anne’s surgery and chemotherapy, and my workload as a solo practitioner, prompted us to go to ‘smell the roses’ in 1996. Touring Australia, working in the Kimberleys (and being glad of RFDS help), Kalgoorlie’s superb Aboriginal Health Service (AHS), and other locums and travel followed, until in ‘99 I saw the advertisement for Broken Hill RFDS and AHS. Our decision was made in a minute – and a new medical experience began: the pleasure of remote consultations when you are the only person in a position to help, the uncertainties of emergency responses, the occasional flare-path landings, the hardy people of a 14 000 square km station who attend your clinic there, the challenge of trying to improve the health of Indigenous friends... then, one day finding you are the only volunteer to lead a great nursing and medical team.
Leanne Brown
Lecturer in Nutrition and Dietetics, University Dept. of Rural Health, Northern NSW

The best decision I have ever made

It was a hard decision to make. To leave a permanent, well-paid city job to move to the bush for a 3 year contract job. In the end it was the best decision I have ever made. I spent a lot of time as a child growing up in rural areas and I longed for a more relaxed lifestyle, less traffic and wide open spaces. Six years living and working in Sydney had taken it’s toll. Moving to Tamworth seemed like a good opportunity to get away from it all.

As a new graduate dietitian in 1995 I thought the only place I would find an interesting job would be in a metropolitan centre, and the first 8 years of my working life were spent in Newcastle and Sydney in clinical dietetic positions. I never thought I would find an interesting and challenging job in the country that offered so much variety, but I did! My current position as a lecturer in nutrition and dietetics at the University Department of Rural Health, Northern New South Wales, part of the University of Newcastle, has given me the opportunity to broaden my professional experience into the areas of research and teaching while still maintaining a clinical role as a dietitian. My working days are interesting and varied. Here is an example of a week in my working life. Monday – I teach a sports nutrition elective. So first semester I am busy preparing sports nutrition workshops, which are then video-conferenced to students on the main campus. Tuesday – An important part of my job is to liaise closely with staff at the main university campus and dietitians who work in the local health service. This involves arranging everything from continuing education for local dietitians, securing local placements for students and visits with rural dietitians. Wednesday – Throughout the year we run inter-professional learning modules for students. This is an opportunity to teach students from different disciplines and to make them aware of the role of a dietitian in the hospital setting with the aim of increasing inter-professional communication in healthcare practice. Thursday – Most of Thursday involves an outpatient clinic. I see a wide range of clients with allergies, eating disorders, weight gain, weight loss and for general nutrition advice. Friday – This is usually my research day where I spend time writing journal articles, drafting ethics proposals, analysing data and preparing conference presentations.

“I never thought I would find an interesting and challenging job in the country that offered so much variety, but I did!”
I was a city girl marrying a seventh generation farmer in the Fingal Valley, Tasmania, thanking my lucky stars that I had nursing to get me out of cooking lunches and baking scones. In the first week I visited the local hospital on the East Coast to put in my work application. I began as the on-call nurse in the back of the volunteer ambulance, and ended up site manager/director of nursing of the then 20 bed hospital. In 1995 the hospital became a community health centre, losing its beds.

In 2001, eight beds re-opened; however, during this time the focus had changed from illness to primary health, and we learnt to stretch our imagination to be creative and proactive with health issues. We incorporated new philosophies and ideas into a region that is principally of low socioeconomic status and has limited resources, services, employment and transport, issues typical of rural areas. As an external masters student with Flinders University, South Australia, plenty of doors opened. The chance to travel to Alice Springs to practice midwifery in a remote environment was fantastic, followed, 2 years later, by participation in an intensive 2 week advance practice course as a mentor, training with the Centre for Remote Health in Alice Springs, developing my passion further in primary health and rural practice. As the clinic nurse back in Tassie, I was preceptor and mentor for university students, a role I thoroughly enjoyed. During this time, partnerships developed with the University of Tasmania’s Department of Rural Health, Medical and Nursing Schools. Our rural teaching site was developed with great accommodation and joint community projects providing enormous support to students and health professionals choosing a taste of the rural experience. And what an experience it is – from the sea to the mountains and valleys in between, Tassie has it all. I dare you to experience it! For me, after work it is out the doors across the paddocks and down to the river where we swim on those warm summer evenings, trying our skills in the kayaks against the rapids or just lazing on the bank watching the trout fly. Now, as district manager for Tassie’s north east rural health facilities, I am working in a more strategic role. However, my passion remains for supporting rural nursing practice and the opportunities it provides for those who reach out and capture what it has to offer.
I come from Mornington Island

I come from Mornington Island with family ties to the Yungaal and Gangalidda people of the Gulf of Carpentaria. I have spent most of my life living in rural and remote areas in north-west Queensland, apart from the time I was at boarding school and later university. I have been working at the Mount Isa Centre for Rural and Remote Health for 5 years. I am married to Maurice and have 2 children, Daan and Yalul. The health statistics for Aboriginal communities are appalling by anyone’s standards.

As an Aboriginal person belonging to an extended Aboriginal family and located within an Aboriginal community, the reality is much more confronting and the impact felt much more personally. Often solutions proposed by government agencies and mainstream organisations have not taken into consideration the cultural knowledge of the community and are dismissive of Aboriginal ways of knowing and doing. Working in a university department of rural health gives me the space and tools to explore the dynamics of these often complex issues. I am able to draw on the expertise of fellow health academics while contributing a cultural perspective that is integral to successful outcomes of any initiative in Indigenous health. Often the ‘experts’ in Indigenous health are non-Indigenous academics who, despite the best intentions and academic training, lack the cultural insight to successfully apply the knowledge gained to sustainable solutions for Aboriginal people. I believe an Indigenous presence in academic settings can, at the very least, make others stop and consider that an Indigenous perspective is important. At best, it can provide leadership on Indigenous health issues by challenging the current ‘knowledge’, facilitating community participation and providing role models for up and coming Indigenous health professionals.

“Working in a university department of rural health gives me the space and tools to explore the dynamics of these often complex issues.”

Catrina Felton-Busch

Co-ordinator, Indigenous health, Mount Isa Centre for Rural and Remote Health QLD
We are very proud of what we have put together here, in a town that has had medical workforce problems for decades.

Sheilagh Cronin
Adjunct Associate Professor, James Cook University
General Practitioner, Flinders Medical Clinic, Cloncurry QLD

A happy, supportive environment

Australia has been my home for 21 years after emigrating from the UK in 1985. I trained in Medicine at Charing Cross Medical School in London and did all my postgraduate training and GP training at the Norfolk and Norwich Hospital in East Anglia. I was raised in the country and although I loved my time in London I have really enjoyed my years as a rural GP in Queensland, initially on the Whitsunday Coast and now in Western Queensland.

The landscape out here is stunning, and over the past 12 years I have flown regularly as part of my work in the Royal Flying Doctor Service Rural and Remote Women’s Program, delivering a women’s health service to the remote towns on the edge of the Simpson Desert. My husband Peter is an accountant and a grazier and working on our property near Longreach over the years has given me a deep understanding of the highs and lows associated with life on the land. I had 12 years working as a busy GP in Longreach, which included running our Division of General Practice. This was very interesting and opened my eyes to the realities of the medico-political scene with trips to Canberra to talk to the Federal politicians. Rural GPs have a lot of credibility there which is shown by the political clout of such small organisations such as the Rural Doctors Association of Australia. Over the past 2 years I have been working with some friends in Cloncurry, setting up an academic teaching practice with the support of the Mt Isa Centre for Rural and Remote Health. We have to train our medical students and registrars in a happy, supportive environment if we want them to return to rural areas as GPs. We are very proud of what we have put together here, in a town that has had medical workforce problems for decades. I believe that we have shown that we can solve these problems by insisting on a good working environment, the best standards of care, working with the community and, most importantly, having fun.
There is just something about country people – their attitudes, their gratitude when someone does something for them – that makes the rural experience so rewarding.

Marilyn Prieditis  
Director of Nursing,  
Regional Health Service, Port Pirie SA

The isolation from mainstream professional education is one of several barriers preventing rural clinical staff from pursuing academic postgraduate education. This results in one of the major issues facing health administrators working with a rural clinical workforce: ‘How do you keep staff developing professionally and maintaining their knowledge and skills to reflect current practice?’

Of greater concern is the resultant mindset that rural clinicians are not up-to-date, compared with their metropolitan counterparts, and the negative impact this has on recruitment and retention. Many methods have been tried to overcome this, with varying but limited success. It was not until the development of the rural clinical schools that any significant success was achieved. Port Pirie Regional Health Service entered into an agreement with the Spencer Gulf Rural Health School to share a position of lecturer in rural nursing. The position is based at Port Pirie Regional Health Service but also fulfils a lecturer’s role with the Department of Clinical Nursing at the Adelaide University. For the university, it means they have a staff member who can contribute to program design and content from a rural perspective, and develop rural-specific courses based on identified rural needs. For the health service, the position promotes postgraduate programs relevant to the local practice setting, supports and assists rural students undertaking academic studies, and acts as a liaison between the students and the university. Since the establishment of this role, there has been increased flexibility in the method of delivery of academic nursing programs, particularly making better use of web technology and video-conferencing, which provide added opportunities for rural clinicians. Now almost one-third of Port Pirie Regional Health Service’s registered nurses have postgraduate academic qualifications in clinical specialties.
“Living in this community has been wonderful for our children, with excellent schooling in the area and opportunities for developing their interests in sports and music.”

Why would we want to leave?

The stunning Fleurieu Peninsula is where I have lived and worked for the past 8 years with my husband Mark, also a GP, and our two children, William and Sam. We are part of a group practice in Goolwa, population of about 7,000, located where the Murray River (sometimes!) exits to the sea. Local industries include tourism, farming and fishing, and many retirees choose to move here for the relaxed regional lifestyle. Practising medicine here is always interesting – we deal with the full gamut of chronic and emergency medical presentations that arise in our broad population.

Our nearest hospital is located in the neighboring town of Victor Harbor and we manage inpatients there. We are also well supported with excellent backup from visiting specialists and a tertiary hospital an hour away by road. I enjoy the diversity of rural general practice and also the flexibility of a profession where I can incorporate an interest in teaching and in the future of general practice in Australia. I am now academic coordinator for a new parallel rural community curriculum which Flinders University Rural Clinical School has instigated in the Hills Mallee Fleurieu region. This is providing a fantastic opportunity for medical students to spend a year of their course immersed in the area, learning from and working beside local medical practitioners. We have added academic support from Flinders University and considerable infrastructure support from the Australian Government. Flinders University Rural Clinical School has created a new master of clinical education course which can be completed online, and this is adding to the teaching expertise of many of our GPs. For the last 3 years I have also had the role of South Australian exam panel chair for the Royal Australian College of General Practitioners. In this role I have enjoyed bringing together GPs from many different parts of the state with a diversity of backgrounds and experiences, and a common interest in maintaining the standards of the profession in Australia. Living in this community has been wonderful for our children, with excellent schooling in the area and opportunities for developing their interests in sports and music. In past years, many rural GPs have felt the need to move back to a big centre when their children have reached secondary school age. For us, educational opportunities in the area mean that we can choose to stay. Why would we want to leave?
Only a speck in time

When I started working at the University Department of Rural Health (UDRH) Northern New South Wales just over 2 years ago, I wondered what had I let myself in for. Professors, PhDs, research. This world of academia seemed so far removed from my world. I was the first and only Aboriginal worker in the UDRH in Tamworth. Will I survive this experience and learn from it, or will I become one of the statistics that the academic world likes to quote so much? Well, I’m still here. I have survived! I have learnt so much – but then so have my colleagues. It’s hard work but its never dull.

What I like most is that although research and academia is a high priority, community activities and local health education is also acknowledged as a valuable tool in assisting our community. As such, the UDRH conducts culturally appropriate senior first aid classes for members of the Aboriginal community. The community expressed a need for the classes so we began to make it possible. We were able to do it ‘our way’ and it’s working. The lecturer has been trained in our way of learning, which includes lots of hands-on, laughing and telling of our stories. First aid kits for the participants are supplied so they have the tools to take back to their communities. To date, four such courses have been conducted with a 100% exam success rate. Hearing positive comments from the participants, and knowing one of them implemented first aid techniques and saved a life, well that’s what makes it worthwhile. So things have changed since I’ve been here. The number of Aboriginal people employed here has tripled. Yes, that’s 300%! There are now three of us and we are in the process of developing cultural protocols with regard to Aboriginal health research, along with embarking on many other collaborations. An outstanding mural is painted on the ceiling of our foyer at the UDRH. This is the centrepiece of the entrance and reminds everyone of the importance of acknowledging my people and of keeping Aboriginal health high on the agenda. My employment with the UDRH is only a speck in time when compared with the immense history and culture of my people. With their help and support I will stay strong and my journey here will be a good one.
Geraldine Duncan
Campus Coordinator,
Senior Lecturer,
University NSW Rural
Clinical School, Wagga
Wagga Campus, NSW

Geraldine’s rural career

I grew up in the Blue Mountains which was really like a village during the 60s. When I completed medicine I wanted to return. However I embarked on a procedural year in obstetrics and my pathway then led me to Wagga Wagga in 1979. I married and set up my own practice as a GP obstetrician while pregnant with my first child. I had four children between 1981 and 1987, taking 3 months off from about 39 weeks and maintaining my GP obstetric practice. At that time in Wagga Wagga there were about 10 GP obstetricians and 6 obstetricians, so support was available. Those were the days! My transition to the university scene came via my involvement as a medical educator for GP registrars.

After the establishment of the Greater Murray Rural Clinical School (of whose inaugural committees and working parties I was a member) I was invited to work with the UNSW. I accepted and managed to merge my jobs somehow. My work with the medical students has become involved and fulfilling. I am the Campus Coordinator for the Wagga Wagga Campus of the rural clinical school. I overview the running of the medical education program which involves keeping up with programs from Sydney, making sure there is a rural flavour, and sweet-talking students and clinicians at times. I deliver tutorials in both the Year IV and Year V components of the course. Running programs rurally places extra demands on already overloaded clinicians. We try to encourage doctors to teach without them feeling their load is increased significantly. Our program allows students from a 6 year curriculum to spend a minimum of 12 months, and even 18-24 months or more, studying here. We try to organise attachments outside in the community both in Wagga Wagga and also in general practices in smaller rural communities. We try for longitudinal contact so that students will revisit practices in successive years. Students have done well in their courses while studying here. To some, this is a surprise. In many ways being a student is more challenging now than it was in the early 70s, especially financially. Rural communities are disadvantaged, some more than others, this has been well documented. I have tried to do my bit for the health of my community. And I hope I have been able to give my students some insight into the value of rural medicine.

“\textit{I have tried to do my bit for the health of my community.}”
Peter Manuel  
*Practice principal, Central West Podiatry, Geraldton WA*

**We see it all**

Believe me, working as a podiatrist in the rural and remote regions of Western Australia (WA) is one of the greatest aspects of my practice. I have a private podiatry practice based in Geraldton, the cosmopolitan heart of the Midwest region of WA. From here I and two other podiatrists travel to remote Aboriginal communities, small mining communities, station homesteads and small townships. We travel by four-wheel drive or small aircraft only, because there is no way ordinary vehicles could make the journey. The scenery changes with the seasons: dry riverbeds in summer and green flood plains carpeted with beautiful wild flowers in winter. Amazing Aboriginal and pastoral history surrounds us as we traverse these outback roads.

There is always time to explore the Aboriginal sites, view ancient rock art and learn about the early station settlers. Apart from enjoying the landscape, podiatry practice in these regions is very challenging. All our skills are put to the test daily because the range of complications and pathologies encountered is vast: from complicated diabetic foot wounds and childhood gait abnormalities, to the surgical removal of foreign bodies. We see it all and have to treat it all there and then. There is no ability to return the next week as many regions are only visited on a monthly basis. The days are long, the travelling often longer than the time with patients, and the accommodation ranges from luxurious bed and breakfasts to swags in community halls. However, the gratitude of our patients is the real reward for working in these areas. Being based in a rural area does not just have career benefits – the lifestyle too is rewarding. My weekends are spent surfing world-class waves in and around the Midwest, diving on ancient wrecks and coral reefs, living without the hassle of city traffic and being part of a vibrant community. Importantly, those of us living in these regions have access to higher education facilities through centres such as the Combined University Centre for Rural Health (CUCRH). I have recently completed a masters degree with the assistance of a CUCRH fellowship and am now well into the training program to become a podiatric surgeon. So it is possible to live in a rural area, have a great lifestyle, a successful practice and to receive a first class education. My wife, two children and I have no intention of leaving here for a while yet.

“However, the gratitude of our patients is the real reward for working in these [remote] areas.”
What could be better?

I graduated from the Faculty of Medicine, University of Western Australia (WA) in April 1977. My grandfather was a UK rural GP, and my Dad a rural GP proceduralist in Kalgoorlie-Boulder, WA. As a lad I was fascinated by the whole process of doctoring. Dad was a very busy doctor in the 1950s and 1960s. He was a renowned anaesthetist and, when on call, was often required to drop everything to anaesthetise for urgent cases. My Dad has just retired at the age of 82; reluctantly, I might say. He still fondly refers to his Kalgoorlie-Boulder days.

During the mining accident in Beaconsfield, Tasmania, he reminded me that in his day the Boulder doctors took turns to go underground to mine accidents. He once brought a miner to the surface upside-down in the skip (lift) because of hypovolaemic shock. The man survived. I always wanted to be a doctor like Dad. If I had done badly in the Year 12 exams my fall-back position was to do forestry. When I get out of bed at 3 am to attend the maternity ward as I still do, I often think of my other career aspiration! In 2002 I saw the need to give something back: to teach. The rural clinical school (RCS) movement had begun and our Head of School, Prof. Campbell Murdoch had arrived in Kalgoorlie. The early days were fascinating as we quickly realised the job could be done. Our colleagues in various disciplines had met and were keen to teach as well. We ran ‘Teaching on the run’ (a module from my own university) in various RCS sites in WA. These days we have 37 students across our WA sites (seven started in 2002). We expect 60 students next year. On 1 July 2006 we begin a collaboration with the medical faculty of the University of Notre Dame in Fremantle. As a result of the collaboration we will be known as the Rural Clinical School of Western Australia. Personally I am delighted with our students’ progress, the collegiate support for the RCS and the community response to what we are trying to achieve. As I write I realise I have now been a rural doctor for 28 years. I still relish my half-time practising rural doctor commitment. The next phase of my career will be more of the same: teaching and practising rural medicine – what could be better?
I worked as a pharmacist manager, followed by working in community pharmacies. On returning to Tasmania in 1996 I was worked as a senior pharmacist at the North West Regional Hospital, Burnie. In this position I was involved in clinical supervision of undergraduate pharmacy students. In 2003 a position as conjoint manager of pharmacy services, and lecturer for the rural clinical school, became available and I jumped at the chance and was appointed. My current work with the rural clinical school involves clinical supervision of third- and fourth-year pharmacy students from the University of Tasmania, as well as providing tutorials in drug therapy and medication safety for fifth and sixth year medical students of the rural clinical school. I developed an interest in the excretion of analgesics into breast milk and the use of analgesics in breastfeeding mothers post-Caesarean delivery. The university department of rural health and the rural clinical school have supported me in developing a research project in this area and have provided resources and the means for me to study as a research masters candidate. It would not otherwise have been possible for me to remain in my employment in a rural area and study for a higher degree. Through my involvement with the rural clinical school and role as a hospital pharmacy manager, I have seen many medical and pharmacy students attend the school and am now finding it easier to recruit young pharmacists to our rural hospital.
Opportunities as vast as the landscape

“*My students at the rural clinical school have inspired me beyond belief.*”

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**Dawn DeWitt**

*Dean, Rural Clinical School, University of Melbourne, Shepparton VIC*

In *Inspiration*—

**My father, a rural surgeon, was an inspiration. Though he died too young with tuberculosis contracted from one of his patients, his ward rounds, with me a tag-a-long child dressed up in a nurse’s costume on Christmas day, left me with an indelible impression of his caring and commitment to rural patients. My first rural medicine mentor was also an inspiration. We spent our postcall days after rounds cross-country skiing and making house calls, with lunch at remote Montana steakhouses. A brilliant man of Norwegian descent, he spends his time off fishing, building a Norwegian mountain hut by hand, and serving on committees for the College of Physicians and other professional groups. ‘Work hard, play hard’, he says.

At work he mentors, encourages, teaches, loves his patients, and revels in their lives and stories. He treated me, a registrar at the time, like a colleague. When we saw our first patient together he said, ‘I don’t know what’s going on with this patient, I need a consult’ (from me??). He inspired me to want to be like him, to emulate his work ethic, his professional demeanour, his warmth with his patients, his thoughtfulness and willingness to rethink puzzling cases, to look for the evidence, to go beyond what was expected. I take this inspiration with me as I try to give students the best medical education possible. My students at the rural clinical school have inspired me beyond belief. They have been positive in the midst of difficulty. They have dazzled me with their brilliance, taught me how to speak Australian medicalese (properly), and inspired me with how they treat patients and debate issues like ‘the meaning of white coats’!

In Australia, we are at a rare time of challenge with serious workforce shortages, with the public unsure that they want to participate in medical education as patients, with students unsure they want to abandon the comforts of city life for the adventure of rural medicine. Work hours changes are changing the nature of professionalism and expectations of healthcare professionals. But, where there is a challenge, there is an opportunity to contribute – and being able to do that, to make a difference – that is what makes life an adventure.
I have to pinch myself to believe it’s true.

On graduation from the University of Queensland in 1986, I was sent to the country for my internship in Rockhampton, Queensland. Back then there was no choice - too many medical students for metropolitan posts meant that some of us had to go bush. I am glad I was sent.

I knew I wanted to become a general surgeon from my fourth year at medical school. My internship year convinced me that I could become a rural general surgeon. I didn’t dive straight into surgery but spent 4 years as a uniformed medical officer in the Royal Australian Air Force first. When I did commence my surgical training I spent 2 years in Melbourne. If I hadn’t been certain of a rural job before, I was certainly convinced after two Melbourne winters! Wangaratta had been one of my registrar rotations, so when a position became available there after I returned from overseas it seemed like a natural choice. That was 4 years ago and I haven’t looked back. There is plenty of varied and interesting work. Since I arrived I have expanded my skills by learning gastric banding surgery. I have been overseas and obtained a taste for laparoscopic colorectal surgery. I have married (a local lad, of course). There are no traffic jams. The weather is far superior to that in Melbourne. I sail, fish and fly in summer, and ski in winter (the snow fields are just an hour away). And at night after I have operated late and walk outside, the air is so pure and the stars so bright that I have to pinch myself to believe it’s true.

“... at night after I have operated late and walk outside, the air is so pure and the stars so bright that I have to pinch myself to believe it’s true.”
Best of both worlds

Hello, I’m a Kurni man married to Lena, an Arrente woman for fifteen wonderful years. I have been living and working in rural and remote Australia all my life, applying my skills to improve the health and social wellbeing of my people as one community, and I must say what a journey of small steps and slow progress it’s been.

Until we have the power and the courage to create our own terms and conditions to direct our future, things won’t improve. I have worked in a number of different professions since the beginning of my career back in 1992: tourism, mining, as an Aboriginal health worker and a community development officer. For the past 18 months I have been in a trainee research position based at the Centre for Remote Health (CRH) in Alice Springs, a joint facility of Flinders University and Charles Darwin University. CRH is a university department of rural health (UDRH) and we also have offices in Katherine and Darwin. I am currently in a capacity building, early career researcher developmental role with the Primary Health Care Research Evaluation and Development (PHCRED) strategy. CRH has helped me to identify gaps in my own research knowledge and we have developed a career pathway that will enable me to become a confident and competent public health researcher. I have taken a journey from not knowing what impact research can have on the whole community (Australia) to becoming more aware of the potential damage research can do. My passion is to ensure the research community doesn’t create further injury and I, like my colleagues, need to be part of it to make this happen. My current projects include evaluating central Australian AFL alcohol reduction strategy – a great challenge for a researcher who is also a footy player and who is passionate about promoting a healthy lifestyle and sport that doesn’t need alcohol to be fun. I’m also a dad and as a family we live in two worlds, one on our outstation west of Alice under the Illawarte Range (Jay Creek). There we look after country and keep the vege garden going through summer, live on solar power and teach the kids how to live and sustain our environment and culture. The other is in town where we work and school and play footy. Best of both worlds; I’d have to say it’s a great lifestyle.
Through the masters in remote health practice I get to meet a lot of remote allied health professionals from all over the country, who are very inspiring in their commitment to their work and their desire to overcome the many challenges they face. Many of these challenges relate to working with Indigenous people who have a high level of disability and chronic disease, and little access to services that many of us take for granted. The centre has developed a course in community-based rehabilitation that attracts students from all over the country, and some international students. I was also able to be part of the Central Australian Allied Health Planning Study which hopefully will be the blueprint for an allied health service in the region. As part of that project we developed a flip chart to help people in remote communities understand what different professionals can do to help their community members. The Centre also supports my active involvement in Services for Australian Rural and Remote Allied Health (SARRAH) which supports and promotes the interests of allied health professionals and our people living in rural and remote regions. Since I only work part time at the Centre I am able to continue my remote area practice as an occupational therapist with Ngaanyatjarra Health Service in remote communities across the West Australian border, and this complements my academic work. Life is never boring when you work in central Australia!
“Breaking new ground as one of Australia’s first very, very remote health service resident pharmacists has its moments.”

Andrew Roberts  
Remote area pharmacist, NT

Breaking new ground

Breaking new ground as one of Australia’s first very, very remote health service resident pharmacists has its moments. I work in public health, alcohol and drugs and do a tiny amount of dispensing. It’s not what I am, a pharmacist, that matters. The surveys demonstrating pharmacy as among the most trusted professions have no relevance out here. It’s the bloke I am – and then it’s what I know about medicines that matters. The work has involved a lot of reaching out, seeking out people to talk with who have no idea or previous experience of what a pharmacist does or can do – with little explanation I get handed the dosette box!

When I visit communities that have no clinic, or the clinic is closed while the RAN (remote area nurse) is on leave, like any other remote health professional I find myself in an extended role, needing to respond to people’s emergency needs. The ‘Robbo first-aid post’ is open – and an RFDS retrieval is more than 4 hours away. In situations like this, if I think something is serious enough to contact a doctor, I hear a slight sound of despair as I (the pharmacist) don’t know how to clinically assess half the things they want me to – I do tablets, not tympanic membranes or toes! On a professional level, I’ve found the best support network is with pharmacists who are also friends and understand me as ‘Robbo the person’. It’s also been very important having regular contact with staff at the Centre for Remote Health who have remote experience and give me encouragement. On a personal level, I’ve found my years of ‘going bush’ and being self reliant a great help. In my endeavours to reorganise clinic pharmacies, my skills operating angle grinders, welders etc are very helpful. I save a lot of time on things like tyre repairs, basic servicing and emergency repairs to vehicles. That I am half handy when I come across broken down vehicles also helps build relationships. I increasingly find myself speaking to specialists, not about scripts for individuals, but about prescribing habits across a population. I may drive 400 km, put in a full day and drive 400 km back. Or I leave home and am not back for a few weeks, staying in dongas or RANs’ homes, making sure I’ve packed the resources to handle the situations and queries I encounter.
“As a lecturer in remote health practice, I get paid to work with ordinary individuals who continue to do extraordinary work in remote health in some of Australia’s wildest country.”

Sabina Knight
Senior lecturer, remote health practice & CRANA Research fellow, Centre for Remote Health, Alice Springs NT

Remote area nursing: nothing, but nothing, beats it!

I love clinical practice; nothing beats the sensation of healing, saving a life, nursing someone in their last days or caring for someone in the context of their family and community. The professional depth and agility demanded by remote practice – advanced and extended care across the lifespan, acute, chronic, end of life, public health and preventative care – all go to make challenging, rewarding and sometimes exhausting work. Growing up on a station gave me lots of practical skills for life as a remote area nurse (RAN). Trouble-shooting the bore, generator or truck, pulling calves, injecting horses or dogs, whipping up a meal for two or twenty, getting on with the job was what you did. My formative public health training was on show grounds and trauma skills honed at rodeos.

I’m a daughter of the black soil plains who now has red sand running strongly in my veins. And nursing has become the passion that has sustained a 30 year RAN career. My focus on remote, rural and Indigenous health has been fuelled by very personal experiences along the way. I started out when a qualification and enthusiasm was thought to be enough, and quickly learnt the same lesson of those who went before me: that people in outback Australia deserve better. Doing nothing was never an option for this RAN, it’s been an amazing time to be around for and to be part of, and I’ve worked with some of the best.

As a lecturer in remote health practice, I get paid to work with ordinary individuals who continue to do extraordinary work in remote health in some of Australia’s wildest country. Our vision to provide support and advanced practice education to RANs before they went bush is on the way to becoming a reality, as has the recognition of the social justice issues of the people who live, work and travel through remote Australia. I’ve been knocked into shape by outback folk, colleagues and the Aboriginal people I’ve worked with along the way, challenged by postgraduate studies in tropical health and the Australian rural leadership program, eaten some of the world’s best meals in very isolated places, met amazing people who have become great friends and inspirational colleagues. I get renewed every year by doing remote locums. I reckon life’s just getting going. Remote area nursing: nothing, but nothing, beats it!
Health professionals can make a difference

I am employed by Queensland Health as the director of nursing at the Boulia Primary Health Care Centre. Geographically, Boulia is about half way between Mt Isa and Birdsville, Queensland. I have held this position since 30 October 1995. My qualifications include midwifery and child health, and I am an endorsed immunisation and isolated practice nurse. I have also completed a Bachelor of Health Management. What started as a ‘bush change’ has now become a lifestyle.

My husband and I came to Boulia with our daughter, Alex, for an expected stay of 18 months. (Alex was due to enter high school). As the deadline approached, we were both enjoying our working and social life and, to cut a long story short, we sent Alex to boarding school, a decision that neither of us regret. I am the sole nursing practitioner in this town. As such you have to learn how to deal with each and every situation that confronts you. These situations can be as minor as a scratch but have extended to major traumas, multi-casualty road accidents and even air craft crashes. I have met and been supported by some amazing people. Some of these were acting in a professional capacity, while others have just seen a need and lent a hand. One of the things I like most about being here is the positive feedback that I quite often receive. There is really nothing nicer than being recognized and feeling that your contributions to the community are valued. While there is a perception that nurses in these positions can suffer professional and social isolation, I have found coping mechanisms such as liaising with the Royal Flying Doctor Service through their clinics and telephone advice, liaising with my nursing peers, continuing further studies and professional development courses. During my time in Boulia I have developed a deep appreciation for the people in the bush and recognize that health professionals can make a difference.
“How to be tired for 25 years - and enjoy it!"

So, they want me to write something advertising the wonders of rural medical general practice! I came here 28 years ago because of a great surgeon who was working here, and because I like anaesthetics. There were three lists a week (7.30 am to 5 pm) and emergencies several times a week. It was great. The surgeon had the good sense to retire. I should do the same, but the way my superannuation stands and with kids at uni, I can’t retire until I’m 80. Where was I? Telling you how to be tired for 25 years and enjoy it. Great place to bring up kids (four of them).

No dough to send them to boarding schools, so I have now done grade 12 five times. Trouble is, I enjoyed having them at home in those years. They are a lot more hard work, but a lot more fun. The girls enjoy them when they are little and messy, but I enjoyed the hard work of their adolescence! Jim Baker always said that you make your own shaped niche in a small country town. True. I don’t have to wear Italian suits (though it would be good to get time to clean my boots). Locums reckon I have the nicest bunch of patients, and they’re right. What don’t I like about working here? I miss adventurous medicine. Flying services bring their own anaesthetists, and emergencies get flown out.

This spoils the fun, and it’s harder to keep good at those things. As I get older I find driving 800 km more tiring than I did at 30, and I don’t like flying. What do I like about working here? Variety of work, lovely patients, a place where you can walk your dog without a leash, and swim in a river 15 minutes from town. You can do all sorts of things in a country town which would be done by professionals in a city. I like playing with computers, sound gear and music. Only problem is the restriction of 24 hours in a day. What does my wife like about it? Looking after small furry critters (including bilbies), ease of getting around town, and again great people. Would I do it again? Yes, though I would try not to work in a solo practice.
机遇广阔如景观

我经常对有人问我关于你的工作时的迷茫表情感到惊讶。也许这与我所在有55人的社区有关。人们假设你与体力劳动或站台生活有关，我认为这反映了更广阔社区对女性及她们在偏远澳大利亚的角色的刻板印象。当你告诉他们你受雇于一个大学的农村健康部门（UDRH），在那里承担学术指导的角色时，他们的态度就会发生明显变化。大多数人会问为什么你住在那里。没有多少可信度，除非你真正生活在这个你为之提供健康护理的社区。这就是为什么我要养八只山羊、一匹马、十二只鸡和四英亩的灌木丛。一个拥有八只山羊、一匹马、十二只鸡和四英亩灌木丛的人与Broken Hill UDRH有什么共同点？对改善偏远地区人口的健康和福祉，尤其是与土著健康有关的强烈愿望。Broken Hill UDRH让我有机会将超过20年的护理和健康管理经验扩展到参与提供学士和高级学士学位的土著健康护理，并直接与来自该地区对健康感兴趣的土著人合作。UDRH还为我提供了自己的研究支持，并允许我在一个受支持和积极的环境中探索研究领域。目前我担任医疗保健主任的职位，这项职务使我们的团队能够跨部门工作，为我们的服务提供更深度的协作和方向。这是一个充满挑战但充满期待和巨大潜力的时代。我们与Maari Ma土著健康公司合作，正在打开联合研究的门户，并在土著健康方面建立更大的相互支持和义务。为学生提供的结构化学习也使我们能够帮助塑造护理学生的课程，他们寻求在我们的地区进行远程或土著实习。我们的机遇广阔如我们所居住的景观。
There have been many constants as well as changes in my rural medical practice...and the potential to extend myself almost unlimited.

John Menzies
General practitioner, Robinson Street Medical Centre, Camperdown VIC

Encouraged by the trusting compliance of an expectant community

This story starts in the operating theatre of the Camperdown Hospital. As usual, time lines are tight. Scribbled notes between cases and the competing demands of the acute ward, nursing home and clinic, are scrunched up, pocketed then tidied up in peace at home over a cup of tea before my dear wife wakes. This is a metaphor for my time in Camperdown.

Camperdown has been a great place to live and work these 30 years – the physical, social and professional environment has been welcoming, sustaining and enhancing – an ideal place in which to grow, both for myself and my family. I grew up in nearby Terang, leaving for further education and taking the sort of journey most aspiring medicos do to acquire the skills thought necessary for rural general practice. The most important acquisition, though, was a life partner who shared my aspirations. Through a series of happy coincidences we found ourselves settling in Camperdown.

The reality has been that my capacity to deliver anaesthetics, obstetrics, surgical, general medical and palliative care in Camperdown has resulted as much from lessons learned ‘on the job’ from valued medical and nursing colleagues, encouraged by the trusting compliance of an expectant community. There have been many constants as well as changes in my rural medical practice these last 30 years, and the potential to extend myself almost unlimited. This has been mainly through involvement with universities, the Rural Doctors Association, Otway Division of General Practice and the Rural Workforce Agency, Victoria, and related bodies. Underpinning this has been the enjoyment and encouragement of working with colleagues on new projects with immediate relevance and application locally, such as the Corangamite Managed Clinical Network in obstetrics. For me, the funding of practice nurses has been a huge paradigm shift and my good fortune to have recruited Beth Royal has made it possible to make systemic changes in my practice, so as to at last make an impact on the outcomes of chronic disease. None of this would be possible if I could not balance my professional life with my personal life, and this I do with my dear wife on a few select acres where we garden and walk the hills. Happily she lets me play my bagpipes and plan more house concerts while she plans the next holiday, usually to our children who are living out their exciting potentials in fascinating places.
What a busy life!

I have lived all my life in south-west Victoria. After completing my education at Timboon I moved to the big town of Warrnambool for general nurse training. I left full-time nursing in 1977 to have my family. A change in career then came as I undertook a hairdressing apprenticeship to work in our family business. I found that to maintain my love of nursing I was able to act as volunteer coordinator at our local blood bank, a role I continued for 20 years. By doing this I still felt I was a nurse and it led to my appointment as associate charge nurse of five regional blood banks.

In a small country town as your children grow you move from one committee to another and become involved with kindergarten, school committee, football, netball, pony club etc. What a busy life! Little did I realize that all this was preparation for my employment at Robinson Street Medical Centre. Four years ago I began employment as Robinson Street’s first practice nurse. This was a new experience for the clinic staff – and what a challenge for me! My first job was health assessments for the elderly with the aim of supporting them in their independent living, a nice easy job after the pressures of blood banking! How things have changed. I soon found that Dr John Menzies was a forward thinking rural GP. As well as dealing with the everyday illnesses that present in a clinic, he had a desire to be involved in preventative medicine and proactive care. What a challenge this has been for both myself and the clinic staff but the people who have benefited are our patients. As practice nurse I have been encouraged to further my nursing career with education and training as we develop our strategies for care planning, the National Primary Care Collaborative, point of care testing, Beyond Blue and chronic disease management, as well as the usual dressings, immunizations and the general running of a busy clinic. How did my earlier involvement help me with this job you may ask? I have had the experience of running a business, paying the bills, dealing with people, organising committees, time planning, deadlines etc, as well as my nursing and caring for patients. Rural general practice is an exciting area to be involved in.

“Rural general practice is an exciting area to be involved in.”

Beth Royal
Practice nurse,
Robinson Street Medical Centre, Robinson Street,
Camperdown VIC
“I would recommend the BHUDRH to any Aboriginal health professional wishing to undertake studies while living in a rural and remote area.”

Maria Tattersall
Indigenous primary healthcare worker,
Broken Hill University
Dept. of Rural Health NSW

Reliable and friendly support

I am employed by Brewarrina Health Service which is in the Greater Western Area Health Service. Brewarrina is a town on the Barwon River in upper western New South Wales, and 99% of its population is Aboriginal. I am an Aboriginal person and acknowledged as such in the community. I wanted to stay in the community and be with my family, but I also wanted to develop my career in a way that would benefit myself and the community’s health. This would never have been possible without the Broken Hill University Department of Rural Health (BHUDRH).

I chose to enrol in the Diploma in Indigenous Primary Health Care Program because I could stay in Brewarrina and be with my family. The BHUDRH provided block learning sessions in Broken Hill that I could attend. My supervisors also made regular site visits to see how I was going. The clinical learning packages were very interesting and could be done at work. These included leaning about blood sugar levels, blood pressure, urinalysis, simple dressings, infant weights, neurological assessment, basic life support, and oral medication administration, to name just a few. These topics were relevant to the clinical needs within the community. There were no delays in getting feedback and support on a clinical and personal level from the supervisors who were readily available. I was able to do exams onsite. The supervisor support at the undergraduate level motivated me to enrol in the Advanced Diploma in Indigenous Primary Health Care. I could not have done this without the reliable and friendly support and advice from the BHUDRH. The Advanced Diploma in Indigenous Primary Health Care is more self-directed and I was able to take electives relevant to my areas of interest. I am currently doing a lifestyle program for women as part of my course, which I could not have done without the skills that I have already learnt in the course. I would recommend the BHUDRH to any Aboriginal health professional wishing to undertake studies while living in a rural and remote area.
I had just arrived back in Brisbane after a sojourn in Europe and was wondering what to do next. I really enjoyed obstetrics but was unsure if I really wanted the lifestyle. While pondering my future I noticed that a colleague with whom I had trained was looking for a locum at her country practice in Home Hill. I felt that a bit of general practice might sort out my professional requirements so I contacted my colleague and arranged to do her locum, all the time wondering where on earth was Home Hill and what would it be like up there. So I arrived and was quickly made at home by both staff and patients. I found the work quite interesting and really got a taste for rural general practice.

To make things more interesting, I met a fellow who was also an import from afar – he turned out to be the local physiotherapist. We struck up a friendship and before I realised it the locum in Home Hill was finished. But the boys for Ayr Medical Centre wanted a locum so I decided to start work there. Soon I was ensconced as a rural GP, initially as a locum but before I knew it I was getting married to my physiotherapist and starting work as partner in the local medical centre! I became more and more committed to general practice, championing it as a specialty in its own right. Next came children – two boys now aged 18 and 15. Now I regard myself, and am regarded by the community of the Burdekin, as a local (after 20 years). Recently I decided to test the waters of remote general practice and, in particular, Indigenous medicine. Although the move west hasn’t been without its difficulties, both my husband and I feel it has been a positive step in my career. There is so much to do out here and the process is exciting. Working in the Indigenous health clinic has been a rejuvenating experience. I have been made very welcome by the patients, and the local medical community is also supportive. I am up to my neck in clinical and public health work. I can truly say that coming from a student in Brisbane to a remote GP has been a rewarding and exciting journey.
Each Indigenous staff member employed by a UDRH is an ISN member. Our members hold differing positions within the UDRHs that reflect a diversity of backgrounds. Positions held include some of the following: associate professors, lecturers, educators, researchers, staff support, cultural program design and delivery coordinators, advocates, resource agents. Our network aims to be inclusive of Indigenous people across rural and remote Australia and strives to assist and support Indigenous communities towards self-determination of local health priorities. Ricky Mentha says, ‘The importance of the ISN to me is the support from within the network that we have. The support and encouragement from the other ISN members is vital as they are the Aboriginal academic health professionals of our times and should be seen as so’. Although the group is quite diverse, Marlene Drysdale says a common theme is to provide an ‘opportunity to recruit and encourage young Indigenous people to think about a health career in medicine, nursing and allied health sciences’. The network also provides support to our members, thereby reducing the feeling of working in cultural isolation. ‘Without the ISN I would have been working in an environment that was isolated and non-inclusive...I would have been overwhelmed with differing opinions and workloads. ISN made me confident in my voice and direction’, says Sharon Dennis. The ISN works towards ensuring that non-Indigenous health workers, professionals and academics are equipped with cultural safety protocols when addressing Indigenous health. To facilitate this process the network has developed a set of cultural protocols and procedures for use within the UDRHs, covering such areas as research, community involvement, cultural safety, student placements and the delivery of cultural training. From Wendy Hermeston: ‘When we sit down in our meetings there is a lot of knowledge around the table. Other Aboriginal academics and educators have already been through those challenges of being a conduit between community and academia. They have a lot of strength and wisdom to offer ways to solve problems because they’ve been there before’. By providing a mechanism for partnerships and alliances with peak Indigenous health bodies the
ISN ensures that representation on Indigenous health issues is presented in a collaborative voice. ‘The ISN is an opportunity for me to participate in a network that has the potential to influence the way tertiary institutions do business, both in general and with Aboriginal communities’, says Renee Blackman. As Indigenous workers we are governed by our local cultural protocols and principles as well as the policies and procedures of the UDRH. While this may, at times, create conflicting interests, overall the ISN works towards achieving positive outcomes relating to Indigenous health, wellbeing and education. The network members are part of their Aboriginal community. This means that extra activities are included in daily life that contributes to their community. An ISN member does not walk away from work leaving their title behind. ‘I am Aboriginal 24-7 so I don’t clock off when I walk out the door. My professional life is my private life. It is all intertwined so there are consequences and repercussions to my actions that non Aboriginal people often don’t understand’, says Amy Creighton.

The ISN works towards a better future for our people while always being mindful of the past. The last words are from Juli Coffin: ‘Working in Aboriginal communities and with Aboriginal people is a privilege. What must be realised is that history, health and consequence are all interrelated, never approach Aboriginal issues without thinking about these three elements as it is today for Aboriginal people’.
You have no idea what a difference you’ve made

You have no idea what a difference you’ve made in my life!’ she said as she hugged me. Just 10 months ago this woman had been very sceptical about videoconferencing. I had a gut feeling that the videoconferencing service was making a difference but wanted more concrete evidence to prove it. In 2005 I applied for a fellowship at the Combined Universities Centre for Rural Health to evaluate the Carers Support and Education Program. This program is the first of its kind in Australia. It offers support, practical advice and networking opportunities for rural and remote carers through videoconferencing.

Trained ‘on the job’ in hospitals in the 1960s, and only returning to nursing after many years away in 1987, I had no formal academic training. Initially the whole experience was scary and I felt quite dumb. I felt overwhelmed and struggled to understand the culture which seemed so different from the clinical world I came from and had mastered. I had never done a literature search before and the process of gaining ethical clearance was totally foreign. Associate Professor Ann Larson was my mentor and she started me on the steep learning curve by supporting me to map out how to achieve the goals I had written for the fellowship. The bit I loved most was doing the interviews and then learning how to put it together afterwards. The fellowship made me realise that research isn’t only an academic exercise, it actually does make a difference to how care is delivered ‘on the ground’. Personally it was a wonderful opportunity, there is no way I would have pursued more traditional academic research study and I would have missed out on the development of this new dimension to my life and work. I now have a greater appreciation of how hard it is to do research. It has helped me understand the need and value of formally evaluating the things you do. They say, ‘It didn’t happen until it is written about’. Well, I have written my paper, the evidence is there, the Carers Support and Education Program project is of value and, best of all, thanks to this formal evaluation the program has been accepted and embedded into the structure of our health organisation. Without the fellowship and the support from the staff at the Combined Universities Centre for Rural Health this work would never have happened. Thank you.
“Working in Longreach has allowed us time for interesting, rewarding work and play.”

**Clare Walker**  
**General practitioner, Longreach QLD**

**Work and play in Longreach**

David and I naively thought that moving to the middle of western Queensland would remove the temptation to have weekends away, go on shopping sprees and spend copious amounts of free time socialising with friends. It was going to be the perfect place to study for our impending RACGP exam while improving our rural medical skills with some long after-hours work in the hospital. We didn’t anticipate making a heap of new friends and participating in social sport or town events, while working a very manageable amount of overtime. Working in Longreach has allowed us time for interesting, rewarding work and play.

Despite the extreme temperatures (the average for January was 39.7 degrees) we have enjoyed our running, mostly because of the great bike track that runs through town and out to the river where the dogs can enjoy a swim. Longreach is the business centre for quite a large area, so there are a lot of professionals who live and work in and around town. One minute we were introducing ourselves to strangers, the next thing we knew I was roped into a social touch-football team, of which David is the new coach! There are now five full-time doctors in Longreach all employed by the Longreach Family Medical Practice, which Queensland Health contracts to look after the local hospital and provide a public medical service. We all share the after hours which involves doing about one week night a week and one weekend a month, which is entirely sustainable. As a result, the workload is very manageable and has enough flexibility to allow for holidays and study leave – even when the tourists hit town in winter. Longreach is a tourist town, largely because of its iconic outback status, plus the Stockman’s Hall of Fame. The tourists are mostly ‘grey nomads’ and although they increase our workload (‘I’ve run out of my tablets ... you know the little yellow ones’), they also provide much needed revenue for local businesses. We look forward to the start of the social netball season (no David doesn’t coach this team), Easter in the Outback events such as a fun run, opera under the stars and a wine and food festival, plus the local show which features a swanky black tie ball. Despite there being so much to do I am sure we will fit in some study, somewhere, sometime...
Opportunities as vast as the landscape

Elizabeth Williams
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Paediatric Physiotherapist, Goulburn Valley Health, Shepparton VIC

Rural relations and rewards

My photo highlights the relations and rewards of my rural health practice, and represents what I love about my life and work. I work at the School of Rural Health, Shepparton where I appreciate the collaboration of the University Department of Rural Health (UDRH) with the School of Physiotherapy of the University of Melbourne.

My work life is varied and flexible, I work with interesting intelligent people, and I enjoy excellent working conditions. Our research aims to improve the health of rural Australians by addressing the acute shortage of physiotherapists and other allied health professionals in the bush. What has my photo of happy volunteers, riders, caregivers and horses at Echuca Riding for Disabled Association (RDA) got to do with why I work in a rural area and why I stay? Surprise! Studies have shown that it is relations or relationships, and a complex array of rewards that attract and keep rural health professionals. I have personalized this principle. Clearly RDA is rewarding but it is more than that. (Incidentally I am the one on the right, a volunteer physiotherapist - and the photo was taken after most riders had gone home.) The example of my involvement with the other volunteers, riders and caregivers illustrates relations with my local rural community. My rewards include being valued by them as a health professional and the opportunity to step outside the clinic and university to promote healthy lifestyles. It is intertwined with my job at the UDRH where I encourage research with clinicians and plan and conduct positive rural experiences for physiotherapy students, including volunteer work. Physiotherapy student accommodation is with students from the rural clinical school and the UDRH, fostering interprofessional relations.

I arrange professional development courses for local health professionals to counter the difficulty of access and the expense associated with attending city-based courses. Intertwined with volunteering with RDA is my clinical work in paediatric physiotherapy, thereby assisting to integrate a child with a disability into the community. What do I love about my rural area? I love the rivers and channels that intersect the region. Here we experience more drought than flooding rains but the outcome is great weather and clever irrigation that transforms the land into an abundant food production area. Mmmm... I’m remembering fresh picked ripe peaches brought into the office by an orchardist colleague! Those rural relations and rewards are subtly working for me again.
Opportunities as vast as the landscape

“I look forward to the clinical placement visits because I travel through the winding hills, fresh water creeks and green-brown scrub, hearing occasional animals noises as they cross my path.”

Sundram Sivamalai
Coordinator,
Rural Health Module
School of Rural Health,
The University of
Melbourne,
Shepparton VIC

Never a dull moment

Hello readers! The 4 week rural health module I coordinate offers all medical students in their fifth or sixth year an opportunity to understand the role of doctors and other health professionals in rural Australia. Here in the bush, my life has ‘never a dull moment’. Apart from work, I play badminton once a week at a stadium not far from my office. I am also a member of the local health and fitness centre, again only 2 km away. A morning exercise in the gym, followed by a swim and finishing off with a spa, sets me up for a productive day!

Oh yes, and getting around is not a problem. I know exactly how long it takes from point A to B, because I am not held up by road traffic. During my lunch break, I can quickly run to my bank, pay bills or visit the post office. Any of these activities only takes me a maximum of 15 minutes. And there is always fresh produce available from the local farms. I have established local contacts in the community, and I am often invited to farms where I can buy fresh produce at only 25% of supermarket prices! My weekends are full of enjoyable activities, particularly visiting local vineyards. I take friends and family on a tour of the wineries for wine tasting (and perhaps drinking!). The friendly welcome and great hospitality of the vineyard owners holds you and you stay longer than anticipated. One of the tasks required by my role is to visit the rural hospitals. I look forward to the clinical placement visits because I travel through the winding hills, fresh water creeks and green-brown scrub, hearing occasional animals noises as they cross my path. The freshness in the air and the beautiful scenery of the hills and rivers are quite captivating. Sometimes I have to stop for a moment to absorb the serene view, while the grazing animals stop their feeding to take note of my presence. Well, I am fortunate to enjoy such picturesque places as part of my job. I have enjoyed living in rural Australia for the past 20 years, since I migrated. I would not dream of working anywhere else, because it offers me the lifestyle that I want!
I had planned to return to a major teaching hospital, but as our first daughter was born and her grandparents lived in Dubbo, we took an opportunity to do a locum there. I rapidly settled in and enjoyed the country medical experience, the welcome of my colleagues and the community, and so I stayed on as a consultant physician/gastroenterologist. I am still here 26 years later!

Working and living in Dubbo has given me great professional satisfaction, with the opportunity to contribute to the care of not only Dubbo citizens, but also to those in the surrounding towns. Being in a small town has greatly reduced the time spent traveling to and from work, allowing me involvement in many social, sporting, cultural and community events. I have been able to coach and referee football, become a Rotarian, and contribute as president of the Westhaven Association (which looked after 200 disabled clients). I was instrumental in bringing the Life Education Van and also SBS television to Dubbo. I have been able to pursue hobbies, such as wood turning, while running a very busy hospital and private practice.

During this time I have had a commitment to medical education, initially to nursing and medical students from various universities. When the School of Rural Health (SRH) was established under Professor Rick McLean, my commitment developed. When Rick was seconded to Canberra I became acting associate dean, a role I am currently enjoying. Having SRH in Dubbo has given me and fellow medical practitioners, as well as the community, a satisfying stimulus. Seeing the enthusiasm of the SRH students and their positive response to the rural experience is reassuring for the future of rural medicine. Living and practising in the country has offered great rewards, both professional and personal. I have been able to raise three children and spend more time with them than may have been possible living in a busier city. It has brought unexpected rewards, such as an award from the Dubbo Business Community, a distinguished Alumni Award from The University of Sydney and a recent nomination as Dubbo Citizen of the Year. I am very happy to recommend and promote Rural practice.
Sixteen years ago I came to the north coast for 3 months’ work, and stayed - like many rural GPs I had been captured by both the variety of work and the friendship of the rural community.

But after 10 years the obstetric unit closed due to workforce shortages and I found myself increasingly drawn into medico-politics and policy work. Ultimately I became the New South Wales president and then national for the Rural Doctors’ Association, and held the position of rural expertise on the Australian Medical Workforce Advisory Committee. A passion for rural workforce naturally leads you to consider the impact of rural training, and the need to do it both more, and better; and my role with the Division of General Practice led to my involvement in the bid that ultimately became the Northern Rivers University Department of Rural Health, where I am now director of education. The NRUDRH has been important for our region – it has enabled us to approximately double our numbers of students and already we have had a number return to the area after graduation. Having a high-class, multidisciplinary educational facility in three main campuses has brought opportunities into the area, and we now video-link to metropolitan grand rounds and speciality meetings, orthopaedic registrar tutorials, and health/research lectures held in Sydney; as well as scheduled educational sessions for the students. We have been able to survey clinicians for their educational needs and where these can’t be met locally have arranged conference sponsorship and flown in experts from other states on topics ranging from psychogeriatrics to pain management. We have video-linked to sessions including urogenital fistulas, international health equity, and bird flu. The NRUDRH research arm supports and attracts to the region people of the calibre of epidemiologist Geoff Morgan, looking at impact of environmental pollutants on rates of childhood leukaemia, asthma and premature labour; and health economist Deborah Schofield analysing the retirement patterns of our baby boomer workforce. This in turn increases opportunities for clinicians to research the local impact of diseases from chlamydia to melanoma. By breaking down the barriers between researchers and clinicians, and increasing the knowledge each has of the others’ skills, it becomes easier to incorporate research evidence into clinical practice and for research to become more relevant to the needs of rural communities.
Life and work in rural Australia

Where do I begin? I love my rural life! When my husband Phil and I were planning where to live, we sat down with a map of Australia to define priorities. We wanted to live in a wine growing region, near enough to the beach to surf, and near flat water to water ski. We wanted to be able to get to the snow for a weekend skiing and, as a newly married couple, wanted to be near enough to our families for them to come and visit but far enough away that they would ring first!

There were work requirements too: I wanted to have access to a hospital to do maternity, and to have more than three doctors in town so I would be on call less than one in three.

My husband wanted more than two high schools in town so he had some career options. I became a GP in Mount Gambier and we embraced all the advantages of living in the Limestone Coast. I still love this region, and my procedural general practice, but in the last 15 years our family and our horizons have expanded. As I have developed as a GP, my healthcare responsibilities have extended beyond the care of individual patients to providing local community medical leadership within the Division of General Practice and local South East Regional Health Board. Through the Commonwealth-funded Flinders University Rural Clinical School, I have been nurtured and supported to build a robust training system to develop our next generation of rural doctors in this region. As academic coordinator of the medical student and intern training programs, I have had the opportunity to establish links with inspiring rural doctors throughout Australia and internationally.

As I have developed a greater understanding of the workforce and healthcare challenges facing other rural areas, I have grappled with understanding why any doctor and their family would want to live anywhere but rural Australia. This is the place where I can deliver a baby before breakfast, walk to work in the morning, be part of an intellectually stimulating research meeting before lunch, supervise junior medical staff in casualty in the afternoon, have a tutorial on the beach and a swim before tea – and go home to eat freshly caught garfish over a bottle of Coonawarra wine with a group of family and friends. As I said – I love my rural life!
**University Departments of Rural Health [UDRH] and Rural Clinical Schools [RCS]**

**UDRH**

1. Greater Green Triangle UDRH – Warrnambool
2. Spencer Gulf Rural Health School – Whyalla
3. Monash UDRH – Moe
4. Northern NSW UDRH – Tamworth
5. Mt Isa Centre for Remote and Rural Health
6. Department of Rural Health – Alice Springs
7. Tasmania Depart of Rural Health – Launceston
8. Combined Universities Centre for Remote Health – Geraldton
9. Depart of Rural Health – Shepparton UDRH
10. Northern Rivers UDRH – Lismore

**RCS**

12. Australian National University Rural Clinical School – Cooma, Goulburn, Bega
13. Flinders University, Northern Territory Rural Clinical School – Katherine, Gove, Alice Springs
14. Flinders University Rural Clinical School – Renmark, Mt Gambier
15. James Cook University Rural Clinical School – Mackay, Cairns, Thursday Island
16. Monash University School of Rural Health – Bendigo, Mildura, Sale
17. University of Adelaide School of Rural Health – Whyalla, Port Lincoln
18. University of Melbourne School of Rural Health – Shepparton, Wangaratta, Ballarat
19. University of New South Wales School of Rural Health, Greater Murray Division – Wagga, Albury
20. University of New South Wales School of Rural Health, Mid North Coast Division – Coffs Harbour, Port Macquarie
21. University of Newcastle Rural Clinical School – Tamworth, Armidale, Moree
22. University of Queensland Rural Clinical School – Toowoomba, Rockhampton, Hervey Bay
23. University of Sydney School of Rural Health – Dubbo, Orange, Bathurst
24. University of Tasmania Rural Clinical School – Burnie, Devonport
25. University of Western Australia and University of Notre Dame Rural Clinical School – Kalgoorlie, Albany, Port Headland
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