

RUSTICA

Annual Report

2004

2004 has been a successful and productive year for Rustica; we have watched club membership grow to an impressive 607 financial members by the end of the academic year. This report details the objectives, budgets and activities of the three branches of Rustica; Southern, Northern and North-West.

OBJECTIVES

- To act as a unifying force amongst members with common interests and goals
- To promote early and meaningful exposure to rural practice and lifestyle
- To promote the positive aspects of a career in rural practice
- To promote exchange of ideas and social exchange with students from other university rural clubs via the NRHN
- To promote within the faculty of health science and to the general public the issues affecting rural medicine
- To provide practical sessions which allow students to learn valuable clinical skills
- To support students from rural backgrounds studying within the fields of medicine and allied health
- To organise social functions, discussion groups and talks by guest speakers
- To develop multidisciplinary approach to rural health and encourage membership of students from other allied health fields
- To liaise with pre-existing rural interest groups and provide student representation at their meetings where appropriate
- To encourage involvement with the RFDS and rural branch TDGP
- To provide encouragement and assistance to rural practitioners
- To promote Aboriginal and Torres Strait Islander health and cultural issues
- To assist the University with promoting of rural health career options to rural high school students

SUMMARY REPORT FOR RUSC 2004

5a. Funding support for the Club: \$23 000 for the period 1st Jan 2004 – 30 Dec 2004, being 15% of the RUSC grant.

Administrative support is the responsibility of the club, and is sourced on an as-needed basis throughout the year. This work primarily consists of data entry and management, communications database, email list maintenance and other overflow tasks that the executive and other members need assistance with, such as sourcing quotations and booking service providers that we engage for numerous functions and activities.

Expenditure for the calendar year 2004 is attached and details activity expenditure and income. Please see the full report that details all activities undertaken and run by Rustica. A complete financial ledger is available electronically and is supplied on CD with this report.

5b. Club Demographics are shown in the report. The numbers of medical students participating in club activities are:

Year	Number
1	85
2	59
3	41
4	24
5	14
6	25
Unspecified	1
Total	249

5c. Student support with reference to the following indicators:

Academic support – not part of Rustica’s data collection, but informal support was provided at various functions by professionals speaking and instructing in their field of expertise.

Administrative support – Jan-Dec 2004: Rustica sourced administrative assistance as required.

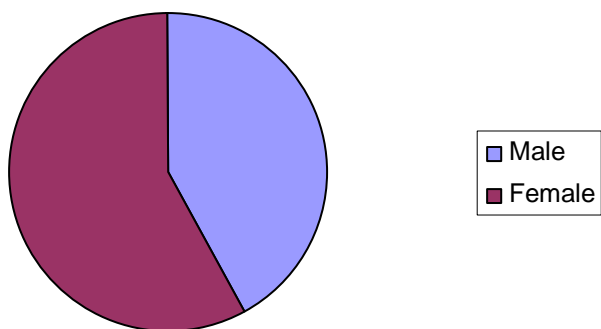
6a. Careers Rustica has previously established a statewide Rural High Schools visit (RHSV) program in 1999, and this was maintained in 2004. It is a very successful program and is coordinated by Ms Rosalie Maynard of the UDRH. Rustica members are involved in providing ideas as well as personnel to visit high schools to talk with students and promote health careers.

7. Indigenous Health Rustica formed an Indigenous Working Group (IWG) in 2002, and whilst limited progress was made this year it has been chosen as one of our major focuses for 2005. Rustica realises the need for Indigenous student recruitment, curriculum content review and has a general acceptance of the need for increased awareness of Aboriginal issues.

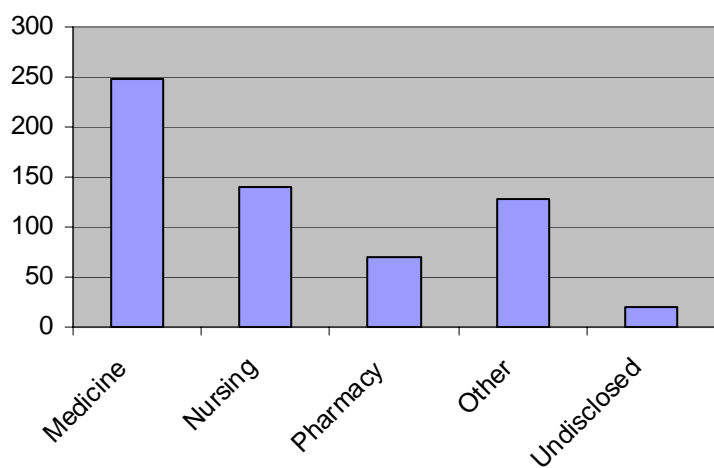
DEMOGRAPHICS

Total Members **607**

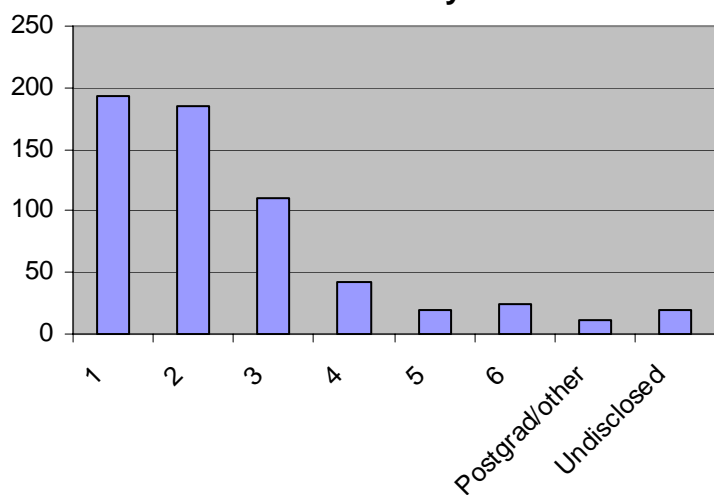
Gender

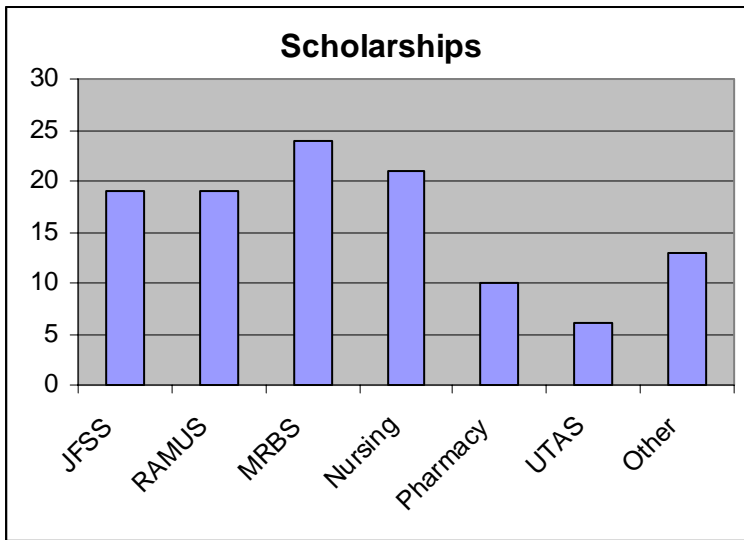


Course



Year of Study





The total number of disclosed members of rural origin are 217. The total number of disclosed ATSI members are 2.

Rustica Financial Report 2004

This is a summary, for which a full ledger copy is available in excel format on the accompanying CD-ROM. Complete details for every transaction are available in the

MYOB file which is also on the CD and requires the MYOB software to view it.

January 2004 through December 2004

Assets	
Total Cash available	19832.1
Cheque account	19532.5
Cash Box Hobart	299.6

Income		% of total
Memberships South	\$1,996.20	5.50%
Activities		
Social Functions	\$727.70	2.00%
Skills Nights	\$595.00	1.60%
Club Clothing Sales	\$88.00	0.20%
Camps / Excursions	\$1,469.00	4.00%
Grants Recieved		
RUSC	\$23,000.00	63.30%
UDRH	\$5,000.00	13.80%
Bank Interest In	\$75.04	0.20%
TUU Funding		
Running Expense Funding	\$3,279.50	9.00%
Adjustments	\$90.15	0.20%
Total Income	\$36,320.59	100.00%

Expenses		
Office Expenses	\$175.13	0.50%
Advertising	\$823.87	2.30%
Printing	\$408.86	1.10%
North West Branch	\$608.60	1.70%
Launceston	\$1,575.28	4.30%
Bankl Fees	\$35.80	0.10%
Agfest & Promo Events		
Travel costs	\$592.80	1.60%
Activities Costs		
Social Activities	\$3,929.84	10.80%
Skills Nights	\$1,403.07	3.90%
Info Sessions	\$1,255.99	3.50%
Club Clothing	\$2,003.46	5.50%
Camps / Excursions	\$2,088.30	5.70%
CME Weekends Travel	\$700.86	1.90%
Conferences	\$3,080.85	8.50%
Club Meetings	\$757.65	2.10%
Donations	\$2,000.00	5.50%
Adjustments	\$0.05	0.00%
bursaries	\$3,878.00	10.70%
Total Expenses	\$25,318.41	69.70%

STATEWIDE SUMMARY

Statewide 2005 Semester 1 Budget

Month	Date	Activity	Cost \$
February	Fri 18	Faculty Welcomes	-
February	Mon 21 – Fri 25	O-Week and Recruitment (Launceston/Newnham)	350
February	Mon 21- Fri 25	Welcome Event Promotion (North West)	200
February	Wed 23	Societies day	650
February	Mon 28 ?	Social Night Welcome (Launceston/Newnham)	800
March	Fri/Sat 4/5	All Branch Committee Camp	1000
March	Mon 8 ?	Rustica/NRHN/WINNOWS/GAPP/Scholarship Info night (Launceston/Newnham)	250
March	Thur 10	Rustica Welcome	950
March	Fri 11 ?	RHSV – Training	400
March	Tues 15	Scholarships Night	300
March	Wed 24 ?	Mental Health Selfcare Night (inc. transport for NW) (Launceston/Newnham)	450
March/April	Mon 29?, Mon 12?, Mon 26?	Discussion Forum (3 evenings over the semester) (Launceston/Newnham)	150
April	Sat 2 – Sun 3 ?	First Aid On the Run Weekend Camp (Launceston/Newnham)	1500
April	Wed 7 ?	Presentation Night: Remote area Healthcare/Nurse Practitioners	250
April	Thur 7	Electives night	550
April	Sat/Sun 16/17	Adventure Camp	6000
April	Wed 21 ?	Skills Night (Launceston/Newnham)	500
May	Tues 3	Skills Night (Hobart)	500
May	Mon 3 ?, Mon 5 ?	Quiz Night (Launceston/Newnham)	300
May	Sat 21 ?	First Aid Course	600
		Presentation Evenings (2) (North West)	400
		ATSI Event	400
Misc		Promotional Material (eg T-shirts, member cards, sign up forms etc)	500
Misc		Office Running Expenses for all branches	2500
Misc		Conference Attendance National and State	2500
Misc		Employment of an administrator	2500
TOTAL			24500

ACTIVITIES REPORT 2004

Orientation Day

Friday 20th of February

As with past years Rustica was once again involved with the first year medical student orientation day program. This consisted of sending out flyers detailing the rural health club and the benefits of membership. In addition to this the 2004 Rustica executive members were involved with a promotional talk to the 120 medical students, as well as the first year pharmacy and science students.

Societies Day

Wednesday 25th of February

Report by Alannah Smith

On Wednesday the 25th of February, Rustica participated in the University of Tasmania's annual Clubs and Societies day at the Hobart campus. The day was a great success, with many people enjoying the sunny weather while they had a few drinks and checked out what all the clubs had to offer them. All the committee members helped out where they could to sign up new members and ensure a smooth, problem-free day. Showbags with Rustica's upcoming dates and lollies were given out, as well as Rustica information, and of course, Boags beer. For those members that signed up for the duration of their course, T-shirts were also given out. At present, there is a backlog of t-shirts, which are being redesigned and made for members.

From 11am until 2:30pm, approximately 200 members were signed up, all from various schools and faculties. All in all Societies day was a terrific event which allowed many people to join up to Rustica and enjoy the festivities.

Scholarship Information Night

Tuesday 9th March

Report by Joanne Ambrose and Ana Phillis

The scholarship night was held in CSLT 1 at the Clinical School. The evening was well attended by students with a total of 60 people.

The following scholarships and issues were showcased by:

Joanne Ambrose - John Flynn Scholarship
Sarah Donoghue - RAMUS and rural high school visits
Caroline Mooney - MRBS support
ADF - ADF cadetships
Leigh Beveridge- University Scholarships
Lenore van de Merwe- QLD rural scholarships
Ana Phillis- NSW cadetship

Material regarding the ADF cadetships, John Flynn Scholarships and NSW cadetship information were also distributed. Following the presentations drinks and pizza were served in Club Med. All speakers were presented with a bottle of wine for their efforts. After the formal part of the evening students attending were given the chance to interact with presenters and ask any questions they may have had. A great night was had by all!

Welcome Bash
Wednesday 10th of March
Report by Leigh Beveridge

The 10th of March saw Rustica's annual Welcome Bash in at the UniBar. This year, held on a Wednesday night, in the barrel bar, an intimate turnout of about 63 mixed years arrived for an evening of fun and frivolity. With nibbles aplenty, and a \$1.50 Boags happy hour, things were set to bubble along nicely.

Unfortunately, the live entertainment was a notable absence, owing to a slight memory lapse on behalf of the bar staff. In spite of this, the Rustica-ites showed good cheer, moving into the general bar at around 9pm, to continue the festivities, to around midnight.

Whilst the turnout was a little down on previous years, those who attended thoroughly enjoyed themselves, and had the chance to cruise and schmooze like professionals do.

Stay tuned for the Kickback planned for next semester, an even more sumptuous and debauched event, to be sure!

Scholarships & Body Worlds Presentation Night
Thursday 25th March
Report by Mike Yeandle

The night was launched by Rosalie Maynard with a presentation on Remote and Aged Care Scholarships. This was followed by a viewing of the "Body Worlds" DVD, which contained graphic images of the exhibition by Gunther von Hagens. A lively ethical discussion on Body Worlds and von Hagen's other work, eg. Public autopsy ensued. The ethical questions of body acquisitions and informed consent amongst many other aspects were debated. A total of 85 people attended this informative night at Newnham.

Continuing Medical Education Weekend
2-4th April
Report by Edward Vergara

Held in the picturesque Cradle Mountain, the CPD weekend was another very popular activity with 15 Rustica members invited to attend. The first day saw dermatology for general practice being the main topic. This was a very hands-on session, which involved Dr. Frances Watkins holding a workshop on the use of a dermatoscope and taking biopsies. The afternoon was spent exploring Cradle Mountain and Dove Lake, as well as viewing the Art gallery at the venue. The evening was spent at a formal dinner with the remaining delegates and the night was a success with the 3 course meal being supplemented with quizzes and activities. The second day saw the delegates go through Infertility with an endocrinologist and fertility expert. This included IUD demonstrations. The afternoon was capped off by a presentation on detecting fraud in general practice, before our delegates headed back to their respective homes.

Northern Branch Welcome Bash – Carnaco
17-18th April
Report by Mike Yeandle

Held in Carnacoo, Paper Beach in the Tamar Valley, the rural bash in the northern part of the state saw a massive event filled with fire shows, light shows, a band and music until the cows came home. An event which raised the bar for future events up north with our new greatly increased membership base and one that required a recovery breakfast and guided walk the following morning.

Tasmanian GP Atlas Launch
Tuesday 20th of April
Report by Edward Vergara

The Launceston Launch of the Tasmania GP Atlas had a big media attendance. It aimed to give exposure to the birth (in the North of the State) of the Tasmania GP Atlas, a website which has the main thrust of aiding with recruitment and retention of General Practitioners to remote and rural areas of Tasmania. It also wishes to assist in the retention of Practice Nurses currently working within the state.

Peter Barnes from the Tasmanian Rural Workforce Agency sees the new website as acting like a "Lonely Planet Travel Directory" for Health Professionals. Along with the "Lonely Planet" aspect of the Atlas is a detailed community directory shown on an area specific basis. This directory can put prospective workers in touch with schools, banks, financial institutions and other services, which would facilitate a much smoother transition to relocation. The website has been linked to Google and other search engines which will make it more readily accessible.

Senator Guy Barnett attended the opening and spoke of the government's drive to provide an additional 1500 Doctors and 1600 Practice Nurses Australia-wide. Hopefully this new electronic ambassador will stimulate General Practitioner, and other Health professional, interest from within Australia and from overseas, helping to fill medical service provision short-falls in rural and regional areas of Tasmania. The Tasmania G.P Atlas can be viewed on: www.gpatlas.org.au

Skills Night – Hobart
Wednesday 21st of April
Report by Adele Zito

Over 100 students participated in the clinical skills night for semester 1. Students attended the skills night from both the Hobart and Newnham campuses. A big turnout including new members attended and on the night the traditionally popular activities such as suturing, venipuncture, and plastering had to offer additional places. The sessions offered were:

- **Sexual Health** *Barbara Lennox (Sexual Health, Collins Street)*
- **Plastering** *Edi Vergara and Melanie Wuttke*
- **Venipuncture** *Jon Lane and Tim Starkey*
- **Suturing** *Tim Marshall and Leigh Dahlenberg*
- **Methadone Program** *Cindy Clayton (Alcohol and Drug Services)*

Adventure Weekend
Saturday 24th – Sunday 25th of April
Report by Mel Wuttke and Caroline Mooney

On a weekend that was cold and wet, one would be forgiven to think that the very popular adventure weekend would have been miserable. Reports from the excited 35 members proved otherwise. Given that abseiling was cancelled as it was too dangerous and given that everyone got wet and spent a lot of time indoors, this did not dampen the spirits of our adventurers. Sea kayaking was still on offer and many took advantage of this and everyone who wasn't wet already got so by the end of the session. The indoor sessions were also a hit with many activities and bonding sessions on offer. Reports had it that "you had to be there". Everyone is excited about another one being organised for next semester.

Caroline and Mel started off with wonderful plans for the adventure camp. The weather had been beautiful all week culminating in a freakily hot night on the Thursday but turned to being

completely ordinary with both of us being woken by the rough weather on the Friday morning. We optimistically packed up the KIA and trailer and headed up the coast to set up.

Saturday turned out to be even worse. The group arrived at 1 and after a quick warm in front of the fire and some lunch, headed off on a walk around the foreshore to glance at where the hazards normally dominate the scenery but they were obscured by cloud. We then hired out the local community centre and had a mini-badminton tournament before firing up the BBQ for dinner. We'd taken a heap of board games and cards with us which entertained the masses until reasonably late into the night.

The next morning, the group was up and about early to take part in the activities run by Aardvark adventures. We had originally planned to go abseiling and rock climbing but the granite had become very slippery with all the rain and 2m waves were hitting the spot we were meant to abseil down into. That left sea kayaking which was a heap of fun in the gentle waves and the water proved to be warmer than being out of it. Some of the group then went for a bushwalk and a bit more exploring around the area.

Gunshot Wounds & Medimate Presentation Night **Tuesday 27th April** **Report by Edward Vergara**

The first part of the evening was held by Danielle Truscott from the National Prescribing Service who gave an insightful talk on Medimate, Radar and other services provided by NPS. From a nursing perspective the main interest was on Home Medication Reviews which is a free service provided to the consumer.

After a coffee break the Presentation on Gunshot wounds and a glimpse into the life of an army medic in tempestuous East Timor, was very ably presented by one of our own students Katie Walker. Graphic slides of Gunshot wounds, both inflicted and self-inflicted served to open the presentation. She then talked through ballistic information with regard to both high and low velocity weapons and their associated projectiles. Temporary and permanent cavities were discussed and demonstrated, with the use of slides of course! A case study, which involved an accidental shooting, was used to good effect to demonstrate procedural information both from military and clinical points of view. Katie concluded her presentation by giving an insight into the life of an army medic posted to East Timor in times of civil unrest. For part of her time there Katie acted in the capacity of forensic pathologist, helping to ascertain cause of death for many East Timorese exhumed from mass graves. We signed up 30 new members on the night and the presentation was enjoyed by a total of 80 students and a few of their guests.

Advanced Studies & Electives Information Night **Thursday 13th May** **Report by Lenore van de Merwe**

We had a really good turn out this year, with around 100 eager members showing up to hear about the experiences and adventures had by fifth and sixth year med students on their advanced study and elective placements. Placements included in the presentations varied from Central Australia, the Top End and Groote Eylandt on the closer side to home, to places as far flung and exotic as India, Thailand, South Africa and the Caribbean. Students who had undertaken research projects and rural Pharmacy placements were also amongst the presenters. Everyone there had a great time, and went home with truckloads of inspiration and ideas to start planning their own elective placements.

Rustica All Branch Meeting
Thursday 24th of June
Report by Edward Vergara

It feels good when a meeting sparks creativity and enthusiasm in people. This was what happened when committee members from all branches and disciplines sat together at the Launceston General Hospital to discuss the future directions of Rustica. Ideas were shared and many of the newer committee members benefited from the experiences of the more senior members. The formal part of the discussions went on for over four hours and some more as discussions were continued over dinner. Plans for the following Semester were finalized and planning for Rustica's involvement at the 2004 AMSA Convention and the NURHC were well underway.

Rustica Kickback 2004
Wednesday 28th of July
Report by Jo Ambrose

On Wednesday 28th of July, Rustica held its annual kickback party to welcome everyone back to Semester 2. Running from 5-8pm at the University Rugby Club, the cruisy vibes were well established as approx. 40-50 members enjoyed live jazz by three-piece "Spiral". A wide selection of yummy finger food and cheap drinks were also available.

Launceston University Open Day
Sunday 15th August

Skills Night
Thursday 19th of August
Report by Alannah Smith

Skills night was held once again at the clinical school, with approximately 70 attendees. The night was filled with many different activities for people to experience, such as sports strapping and massage, venipuncture, suturing, and discussions on palliative care. The night ended with pizza and drinks and it was thoroughly enjoyed by all.

Hobart University Open Day
Sunday 22nd of August

Rustica/TAPS Kickback
Friday 17th of September
Report by Alannah Smith

The Rustica/TAPS kickback was held on the 17th of September, 2004 and it took place at the University's Rugby Clubrooms from 3-7pm. This event was mostly attended by pharmacy students, although everyone was invited, especially the first and second year medicine students as they are on the Sandy Bay campus.

This was a great opportunity for the pharmacy students to get to know, and party hard with each other. It was important that Rustica be involved with this kickback as pharmacy students are still little cautious and unsure of what Rustica can do for them. The kickback was therefore a great way for the students to see what Rustica can do for them, and meet some other members of the Rustica executive.

The night was a great success, with everyone having a fabulous time. Approximately 100 people arrived, ready to start socialising. The weather was on our side for this event, as it was a beautiful afternoon: perfect for a few drinks and a yummy barbecue.

A thankyou needs to be extended to the TAPS executive as this event could not have gone ahead without the support of these people, who gave much of their time and energy to get this event up and running.

Pharmacy Skills Night
Wednesday 22nd of September
Report by Alannah Smith

Rustica's Pharmacy Skills Night was held on the 22nd of September from 7-9pm at the Sandy Bay Campus. This event, although in its lead up was met with much enthusiasm and support from the pharmacy students, was not the great success it should have been. This was very unfortunate as there had been lots of advertising in the weeks leading up to it, and all the students were very interested in the topics, but they didn't come through on the night (much of which was blamed on bad weather and study).

However, the students that did turn up enjoyed the speakers, and learnt a lot from them. The speakers were absolutely terrific and gave us lots of useful information. We had sessions on wound care, sports strapping and medicine and natural medicines. The evening was followed by soft drink, snacks and pizza.

A big thankyou needs to be given to the TAPS executive who helped to plan and run this event.

NURHC 2004
Tanunda, Barossa Valley, SA
Contents:

- 1) **Keynote speaker and concurrent session reports**
- 2) **Discussion topic reports**
- 3) **Social overview**
- 4) **First aid on the run**

Wednesday 29th September

Keynote Speaker:
How health professionals look after themselves – the concept of well being.

Dr Roger Sexton, Mt Pleasant Medical Centre

Report by Sarah Donoghue

The Dr DOC Program

Dr Roger Sexton provided an entertaining and rather thought provoking view into the health of rural health professionals. He described his context as having a rural background himself, doing a rural elective in his fifth year of medical training before going to the UK to gain additional experience. Dr Sexton's view on rural health care was that rural health outcomes are not only disadvantaged for rural people but also for health professionals. He felt that this was because the health care that

could be accessed was not always appropriate and that adverse outcomes affected the quality of delivery of health care.

***When health is absent
Wisdom can no longer reveal itself***

- *source unknown*

It was initially in 1999 when the issue of impairment to seeking health care registered with Dr Sexton when he was confronted with the issue of a rural GP addicted to pethidine. This GP had been self medicating headaches that had developed from the demands of rural practice. Dr Sexton stated that it was a situation that could have developed from any person involved in rural general practice, where the creation of a patient without a doctor occurred.

Dr Sexton was asked to set up a program reflecting a duty of care, it was a federally funded program involving the GP workforce and focused on the various tiers of difficulty a GP could be expected to encounter and involved strategies such as education and crisis management options. It emerged that some of the issues facing GPs were that there was difficulty accessing health care for themselves and that they felt somewhat unsupported. About 10% of rural GP's felt deskilled and 40% thought they would benefit from personal skills training. Perceived barriers included medical myths which encompassed a range of expectations starting from general myths such as, doctors don't get and involving more personal issues, such as you have to made of the "right stuff" to be a doctor. Dr Sexton highlighted the culture within the medical profession as competitiveness versus collegiality where doctors are so used to competing to be the best that any sign of perceived weakness might be misinterpreted as not have the capability to perform adequately, or in layman's terms "they don't have the right stuff".

The Dr Doc program aimed to address these issues by providing the following :

- Culture of caring
- Choices
- Country centred
- Core business
- Continuing Professional Development
- Confidentiality
- Clarification
- Cochrane (based on evidence)
- Collaboration
- Crisis support planning

The Dr Doc program proposed to achieve its aims by the following:

- Pamphlets
- Crisi plans
- Long service medals
- Retreats
- Website
- On call professionals
- Research
- Check-ups
- Linking GP's

Out these the GP's found the retreats and checkups the most valuable. The Dr Doc program aimed to be evidence based and it reduced the number of doctors going to the medical board and the doctors thought that there was improved support and health.

Dr Sexton identified that there were multiple stresses facing health care students both prior and subsequent to graduation. He highlighted issues such as time management, finances, academic burden and personal problems. He said that subsequent to these issues people may develop a range of problems, including failure to communicate adequately, relationships and problems with perceived humiliation. He said that 40% would have anxiety, 10% would have depression and 40% would use alcohol as a coping strategy. He said that the early development of these problems could lead to the reinforcement of bad habits in late life resulting in problems functioning both effectively as a health professional and person.

He said that time management was a big issue, and that much of our life revolved around keeping to time. He also discussed issues such as:

- On call
- De-skilling
- Practice management
- Balancing work and home life
- Family fragmentation
- Partner difficulties
- Demanding patients

Dr Sexton addressed the issue of handling stress, he said that we had a tendency to speed up instead of slowing down and taking a look at the issues stressing us. He said that we listen to other people in the context of depression but we need to be able to recognize the early warning signs of depression in ourselves. He said that there were multiple reasons why people might not seek help for their depression but these were normally balanced by supports in people's lives. He emphasized that we need to develop and retain these supports and networks, which may be medical, family or other. He said that getting the balance wasn't easy and quite often there may be things that drain you.

Dr Sexton concluded by addressing the fact that we need to do things that help to keep us happy and have a frequent spring clean in our lives. He said that we may need to take time out to take care of ourselves and maintain interests outside medicine. He said we need to maintain our supports and be able to recognize when we need help and others need help. Dr Sexton concluded on the following note:

*“Careers in health will clash with life.
There are many positives to a health career.
We can only help others from a position of strength.”*

Concurrent Session A

Report by Anne-Sophie Rowcroft

The simple complexities of providing culturally relevant healthcare in Kakadu

The township of Jabiru in the heart of Kakadu National Park is a diverse combination of Aboriginal and Torres Strait Islander (ATSI) peoples, non-ATSI Australians, and countless tourists throughout the wet and dry seasons. ATSI peoples comprise about 30% of the stable population of Jabiru and adherence to either mainstream Australian or traditional Aboriginal cultures ranges from near-absent to near-complete in both directions. Their traditional socio-political system and prevailing problems with integration into the mainstream Australian system is manifest in a relatively poorer

level of education and as well as poorer overall health. This is evidenced by lower use of healthcare facilities and other markers such as prevalence of communicable disease and nutritional status.

One commonsense strategy to educate local ATSI people about healthy eating and obtaining adequate nutrition has been to describe the healthy food pyramid in terms of bush tucker and other relevant foods. This impacts on those who do commonly gain their sustenance from the bush, to those who partake of social and familial gatherings and mix with the aforementioned group, and to those who see the efforts of the healthcare system in trying to provide culturally appropriate resources for the ATSI community.

Other successful examples of interventions exist and, unfortunately, so too do unsuccessful attempts. Understanding the needs of the community involves active cooperation between all stakeholders in order to maximise the yield of any healthcare strategies implemented.

Staying rural? A review of the general practice workforce of the limestone coast.

In trying to understand what attracts health professionals to work in rural practice we examined the South Australian Limestone Coast's general practitioners, their demographics and community, workplace and personal issues relating to why they worked there and why they planned to stay in or leave the region. Data was collected with a questionnaire that included queries regarding their background, their exposure to rural health during their studies, what attracted them to rural health practice, how long they had been in the region and how long they planned to stay. Further questions then centred around reasons for staying/leaving rural practice. The questionnaire was distributed to all 56 GPs registered with the Limestone Coast Division of General Practice (LCDGP). The views of practice managers, key divisional members, head of Greater Green Triangle Parallel Rural Community Curriculum (PRCC) and a representative of the Penola Medical Workforce Support Group were obtained through interviews. This was to gain additional and/or supporting views on the reasons why GP's come to, remain in or leave the region.

The perceived advantages for coming to the region prior to arrival were consistent with the current influences for staying, these included lifestyle, attractiveness of the region, established rural community, ability to do procedural work, diversity of medicine and oversees trained doctors on training programmes. The main influences towards leaving the region, as indicated by GPs and confirmed by our interviewees, were cultural and social isolation, insurance and indemnity issues, children's education, excessive on-call requirements and spouse social and employment needs.

The decision to stay in or leave rural practice appears to be influenced by a complex dynamic equilibrium between attractions and disincentives. Of these, many are inherent to rural medical practice nationwide, others are regionally specific. Modifiable issues highlighted in this study as needing continuing attention in the region included cultural isolation for both overseas trained doctors and Australian trained GPs; and insurance and indemnity issues. The need for community support programs and continued surveillance of GP issues was identified as important in tailoring solutions to address the issues raised in this study.

A Schema to Facilitate Teaching and Learning about Aboriginal and Torres Strait Islander Health *Dr Tamara Mackean Flinders Medical Centre*

The Flinders University School of Medicine commenced the Graduate Entry Medical Program (GEMP) in 1996. As well as having a presence in teaching hospitals in Adelaide (The Flinders Medical Centre and The Repatriation General Hospital), the School has a significant and expanding rural and remote presence with clinical training and research activities in regional areas of South Australia, as well as Darwin and Alice Springs in the Northern Territory. Within all these settings the GEMP students are exposed to Aboriginal and Torres Strait Islander health issues to vary

degrees. For example, year three GEMP students can undertake their studies at Royal Darwin Hospital, which has a very high Aboriginal and Torres Strait Islander inpatient population. Other teaching hospitals, such as the Flinders Medical Centre, do not have high Aboriginal and Torres Strait Islander inpatient populations but because of the burden of disease experienced by this group, there is still significant interaction between the students and Aboriginal and Torres Strait Islander people. In order to prepare students for these clinical encounters the GEMP has a compulsory Cultural Awareness Camp early in first year, which introduces issues in relation to Aboriginal and Torres Strait Islander health and culture. The challenges that the FUSOM face with the teaching and learning of this subject matter are varied and complex such as how to make it a student priority; how to integrate it into the overall curriculum; how to incorporate fundamental issues such as colonisation and cultural oppression and relate them to current health status; and how to ensure educators are culturally competent in their teaching of knowledge, skills and attitudes. In response to these issues we have created a schema of Aboriginal and Torres Strait Islander health titled "Perspectives on Aboriginal and Torres Strait Islander Health". This schema incorporates both the individual and community experience and draws together the issues of health and dispossession with a focus on the cycle of poverty. This allows the reader to consider the fact that the cycle of poverty is not unique to Indigenous Australians but the reasons behind it are. It also provides a framework for future teaching to extend students' understanding rather than repeat similar information. We also intend to use the schema for the purpose of giving our educators a simple but comprehensive overview of the issues that will allow them to better facilitate discussion and learning. SA

Academic Opportunities for Medical Students in the Territory! ~ *Mr Glen Wallace Northern Territory General Practice Education Ltg*

The Northern Territory RUSC program has provided positive outcomes in General Practice, Aboriginal, Rural and Remote Medicine for medical students since 1997. The developing face of the Top End and Central Australian Programs now see over 200 students pass through the program annually, and increasingly through the integrated learning model NTGPE has developed for medical students, junior doctors, registrars etc.

NTGPE provides an important link between student placements and supporting the Rural/ Remote Workforce throughout the Territory. Evaluations made by all students completing placements reflect the positive impact this program is having on medical students' interest in pursuing a career in a rural and or indigenous health on a national scale.

In 2003, 74% of students that completed placements and evaluations of their experiences recorded a greater interest in rural practice following the experiences and outcomes of their CA RUSC placements.

CA RUSC placements are confronting and students undertake a huge professional and cultural learning curve regardless of their background or level of education. Students are not shielded by the comfort of conventional health care delivery -large Town Practices and Hospitals are replaced by small health centres that form the primary point of contact for a people rich in culture, poor in health - the Aborigine.

This opportunity inspires, impassions, and at the very least, medical students are left with cultural knowledge of Aboriginal people that will ultimately benefit and positively influence their future practice and patients alike throughout their careers.

Concurrent Session B **Report by Caroline Mooney**

One Step in a Journey of Questioning

Ms Carita Davis, Northern Territory Remote Workforce Agency

Megan Post, President of the Central Australian Remote and Aboriginal Health (CARAH) Club

Rural High School Visits have been happening in Central Australia for the past three years. As the only undergraduate students in Alice Springs are nursing students, in order to successfully deliver the program, other allied health students are flown in from around the country. The huge amount of interest in the NT RHSV program meant that a different selection process had to be developed. It was also noted that the RHSV CD was not culturally appropriate for the students in Central Australia, highlighting the need to change the current program.

The undergraduates underwent a week cross-cultural awareness training before beginning their two week long RHSV program as for many, this was their first interaction with Aboriginal Communities. The program was received very well, with the aim of encouraging more people to work in the communities.

Twenty schools were visited and 17 workshops undertaken in a whirl-wind tour. Many kilometres were covered in this time. It was estimated that it took 35 000 km to get to the Territory, 2 500km by road, 3 140 by air, and 40 640km were covered in two weeks. Some schools drove up to 720km to attend the workshops.

The students attending the workshops were hugely diverse, in terms of living conditions and literacy levels. This highlighted the need for flexibility when delivering the program. Hands on skills were incredibly popular and included introduction to things such as plastering, stethoscopes, BP, OT tools, and the ever popular anatomically correct bear.

It was recognised that standard RHSV programs are not appropriate in indigenous schools, especially as most students often don't come into contact with a health care providers, therefore the NT RHSV programs need to focus on health care providers relevant to their lives and who they can talk to.

The disparity between communities is painfully obvious. "Looking at the other side of the rock," poverty is only 20km from the five star hotel at Uluru. In a place such as this, indigenous and rural health are just SO important. If multidisciplinary students can work so productively together at an undergraduate level, primary health care in the future will be built on strong foundations.

"The more I know, the more I know I know nothing" – Socrates. Knowing the limitations leads to increased passion for working in rural and remote places. This in turn leads to a deepening awareness and increased skills in cultural safety. The sign at Nhulunbuy high school says it all, saying "Bacteria – the only culture some people have." We have a long way to go in educating people.

In 2005 ten interstate students are needed to run RHSV in the Top End. Subject to funding of course.... At the moment, there is zero funding for RHSV in the Northern Territory.

The growth of a rural health club - from waalhiibe to kangaroo

Discussions at recent NURHC conferences have highlighted the uphill battle that many purely Allied Health Clubs have in recruiting and retaining active members. This phenomenon is further highlighted by the analysis of 2003 NRHN demographics, which shows that allied health members

make up only 27% of the NRHN, despite their being seven purely allied health clubs and many clubs whose membership is open to both medical and allied health students.

Since its inception in 1999, the WAALHIIBE club has been guided by the structure and activities of its sister club, SPRINRPHX (medical and dentistry). After years of low membership and low attendance at club functions the club executive has abandoned the 'medical model' and employed strategic and marketing strategies aimed at making the club, and its activities more appealing to its target market. Innovative marketing strategies have been utilized, and there have been drastic overhauls in both the timing and structure of club events. Such measures have already proven to be very successful, with average meeting attendance currently sitting at an all time high, with an increase of over 60% from last year. The presentation will outline some of the strategies already implemented by WAALHIIBE, hopefully acting as a catalyst for discussion amongst other clubs for the remainder of the conference. The presentation will be of great interest to executive members from all clubs, but especially allied health clubs who believe that through innovation and change their Rural Health Club will have opportunities for further growth.

What the people want – Delivery of Australian rural health services:

The Interdisciplinary Approach

As students who will be the next generation of health professionals, it is important that we identify and implement innovative and pro-active approaches to strengthen rural health services from the ground up. A fundamental but critical role of healthcare in rural areas is early intervention services for children below school age. It is important that effective management of this group is a priority for health professionals and other stakeholders. Research evidence suggests that this can be achieved through the introduction of interdisciplinary teams where a group of professionals work together with the parent to manage a child's care. Debate among health professionals persists as to which discipline is best equipped to undertake initial screening and assessment and who should provide ongoing management and support to children and families in rural communities. This further impacts on service delivery. As waiting lists get longer and caregivers spend countless hours going from one health professional to another, it is time for our rural health services to look at an alternative option for early intervention services. A focus toward interdisciplinary teams has been shown to not only assist the child but also the caregivers. Statistics from a rural health area signifying the number of children requiring more than one form of support and an overview of local and international research substantiate the need for an interdisciplinary approach to early intervention. It is suggested that when a child is viewed in a holistic way they will respond more positively to a therapy program. The Interdisciplinary Dysphagia Clinic (IDC) at The University of Newcastle demonstrates that an interdisciplinary team can produce positive outcomes not only for the child's care, but also to empower caregivers into taking a pro-active role in the child's intervention program. In addition, unique learning opportunities are created for students and the team itself.

Mental Health: Lessons from a Tragedy

The year 2003 ended with a double tragedy for The University of Western Australia Medical School losing two final year students to suicide. One of those who took his own life was an elected member of the 2004 SPINRPHX Executive Committee. Joel Carson was not only popular amongst the rural health club, but also amongst the greater medical fraternity of Western Australia.

Through our presentation at the 2004 NURHC, we wish to share with other delegates our own personal experience of loss and what our rural health club is doing in response to what has happened.

The presentation will reflect on the life of Joel Carson, the events of last year, and what has happened since. This will include a detailed account of a recent SPINRPHEX meeting devoted to student mental health called 'Looking After Yourself – who is looking after you?' We will also discuss scholarship funds, which have been temporarily put on hold as a result of last years tragic events and how the SPINRPHEX Rural Health Club intends on redirecting those funds into the youth of a rural community in need.

Our objective for this presentation is to pass on the message to delegates of just how important it is to look after yourself and also to look after your peers. This is a lesson we have learnt through very tragic circumstances.

This is an experience of what has happened to our rural health club and how we have dealt with it. This is not just an academic hypothetical issue to be discussed but is a sad reality for us in WA. Through loss we have gained strength.

Concurrent Paper Session C **Report by Ashlie Hill**

Experiences of the Rural and Remote Communities of St. George and Surat

St. George and Surat are both located in rural south-west Queensland. The nearest large town is Roma; 79 kms north of Surat and 189 kms north of St. George. Both towns are five or six hours drive from Brisbane. Due to the distance from other services, healthcare professionals in these towns need to be innovative with both their equipment and skills.

Surat has a population of 500 people. Edward Lyle had a one week placement there, in which he discovered that the town's healthcare system consists of one doctor, who doubles up as the town's pharmacist and runs the ten bed hospital, and an outreach program to 'nearby' Glenmorgan (60 kms east) and Wallumbilla (90 kms northeast). The Glenmorgan health clinic is situated in the local CWA hall, and the Wallumbilla hospital is a modified house with one bed.

The shire population of St. George is 2800, it has an aria rating of 7.4, which is classed as remote. Edward completed a three week placement there. At St. George there is one doctor that worked at the public ten-bed hospital and ran outreach clinics, as well as four doctors with rite of private practice. As well as these 'constant' healthcare professionals, allied health workers come on a regular rotation from Roma; these include a radiographer, mental health worker, occupational therapist, physiotherapist, nursing staff and a visiting flying surgeon. This is a multidisciplinary healthcare team, many attend the hospital on a part-time basis. As a result in can take up to three months to get something as simple as a physio appointment. This forces many people to travel for treatment.

Rural nursing forms the backbone of the healthcare service. They provide an after hours service and due to a lack of healthcare professionals, they get more clinical experience which leads to a nurse-practitioner role. They gain more experience in a larger variety of cases than is the case in urban nursing.

One large area of healthcare in this region is that of the Indigenous community. There is a high level of morbidity in the local Indigenous community (which is largely made up of the Mandandanji tribe, meaning 'fishnet' tribe). A loss of culture due to European settlement has led to a high incidence of mental illness. There are many Aboriginal elders still present in the area; the

Indigenous population is 350 people, which comprises 12% of St. George. Aboriginal healthcare workers are now employed in the area to 'bridge the gaps'.

Rural health practitioners are on-call a large part of the time (especially if the only practitioner in the nearby area) and as such get to see more emergency and obstetric cases. Their isolation requires them to be a 'jack-of-all trades'; and demands a knowledge of access to specialist care and an extension of skill bases to enable them to provide the optimum patient care.

1st and 2nd year Rural Weeks – a health service and community participatory approach

The Spencer Gulf Rural Health School's Rural week is essentially a week-long 'immersion' project in a rural area, designed for first and second year medicine students from the University of Adelaide. It aims to add a rural context to student's perspectives; by applying an urban curriculum to a rural community, and also adding rural content related to health, the community, and disparities between rural and urban healthcare. The program is compulsory and the 120-odd students are spread six learning centres based around the Spencer Gulf.

The program has been shown to be a useful experience for not only the students, but also members of the local community, with many of them volunteering to take part in the project and enjoying it. These include members of the Minlaton volunteer ambulance service, community based allied health staff, local business owners, local sporting groups and clinical practitioners. The outcomes are positive for both students and the community.

Student outcomes were evaluated using pre- and post-program attitudinal surveys, and an analysis of their participation in group discussions. After the program, 63% of students said they would consider undertaking long rural placements in the future, and 82% said they would consider working in a rural area.

The program doesn't only assist the students. The community's healthcare system receives a boost from the information exchange between university staff and local health service staff that are transferred into the area for collaboration. There is a sharing of resources, and local ambulance groups have labelled their participation in the program as 'empowering'.

The next step is a formal evaluation of participating members of the community, to assess the outcomes the program has on them, and potentially improve the outcomes for the future. Some questions to be asked:

- Could this be a model of recruitment and retention, as the capacity of the rural community continues to grow?
- Does this program only work in communities that 'need help'?
- Will this result in a higher influx of long-term rural placements and eventually rural practitioners?

Primary Health Prevention in the Rural Setting – The pharmacist's role in the school setting

Jason Christopher – RHINO

The teenage years can be the most traumatic in any person's life, and this can be magnified in rural and remote communities where there are few opportunities to develop their own unique identities, and limited support facilities. It has been statistically proven that there are more teenage problems in rural and remote areas, as compared to their urban counterparts.

In teenagers, mental health is a very large contributor to the burden of disease, and injury (including accidents and suicide) is the leading cause of death. The suicide rate stands at 15.1 per 100 000 per year, drug-related death rates are not declining, 25% of teenagers smoke on at least a semi-regular basis, and 22% of 15-24 year-olds are overweight or obese.

In rural areas, the youth suicide rate is up to five times higher than in other regions, and the indigenous suicide rate is two to three times that of non-indigenous people. These high rural suicide rates are related to low socio-economic status and lack of community support. A lack of easily accessible, appropriate healthcare facilities also helps to impound the problem; often in rural areas the healthcare facilities are over-generalised extensions of urban programs, which have little relevance to the unique problems encountered in rural areas. Also, the conditions that young people in these areas are more likely to encounter are less common reasons for presentation to a GP (i.e. mental vs. physical problems).

Family and school-based intervention plays a part towards alleviating these issues, to reduce problems related to antisocial attitudes, substance abuse, bullying and sexually risky behaviour. However, the Australian education system is too oriented towards academic excellence, and little emphasis is given to the teaching of life-skills. The key to helping adolescents through, with education and experience, is to implement a program with life-style skills. This can make the adolescent community more aware and decrease some of the associated health burden. One factor of this approach would be to highlight the pharmacist as an easily accessible, free consultation medium.

By involving pharmacists in the primary healthcare team in these areas, it could help to ease the burden of the shortage of qualified, experienced healthcare professionals. The pharmacist has the most potential to expand their skills, and is often considered to be grossly underutilised. They are freely accessible, and don't require a formal consultation to be booked, they are highly knowledgeable and qualified and ought to be strongly encouraged to diversify. This approach does not suggest that rural communities should rely solely on pharmacists, but should take the advantage to utilise them to the greatest ability.

Is rural health sexy? – The profiles and barriers of rural health practice

Mark Chantachak – ROUSTAH

Rural health practice differs greatly from that in the city. Healthcare is a very important factor in all regions, but different perspectives are found of health practice in the different areas. Rural professionals see advantages of rural practice as being the spur-of-the-moment nature of the practice, the friendly locals and community support, the opportunity to attend to a greater variety of cases, and the ability to provide more personal care.

The concerns related to rural health practice include the long distance to travel to reach specialist services, the continuing shortage of healthcare professionals, the short opening hours of business, lack of public transport and low frequency of stock delivery. Suggested improvements include an increased number of specialists and longer business hours.

City-based healthcare professionals view rural practice as being more stressful, the service very demanding and express concern at the necessity of house calls at late hours and demonstrate a reluctance to send patients long distances to access specialist services. One upside is the ability to have informal meetings with other professionals.

On the other hand, city professionals think of the city as being a positive environment, due to easy access to other specialists, and services being easily accessible by walking, driving or public transport. Negative aspects include the impatience at full waiting rooms and less ability for personal interaction.

Students views of rural practice express positives as including not being rushed for time, and negative as the lack of specialists and dentists. They view the city as having many specialists nearby, but express concerns at having to wait long times to see a doctor.

Thursday 30th September

Keynote Speaker – Where will you lead? The social and economic determinates of Policies for Rural and Remote Health

Mr Gordon Gregory Executive Director National Rural Health Alliance

Concurrent Paper Session A

Report by Jo Ambrose

Online Technology Via The Bush Telegraph,

Georgia Brown, Sue Pougault, SPINRPHEX

‘Many of life’s failures are people who did not realise how close they were to success when they gave up’ Thomas Edison

Georgia Brown from the University of Western Australia quoted Thomas Edison as she related her experiences and the barriers she faced as a rural high school student applying to study medicine at university. She listed her experiences as one of the reasons she became involved in the ‘Choose Medicine – The Rural Student Recruitment Program’.

The Western Australian Centre for Remote and Rural Medicine received funding to develop a pilot project website aimed at reducing the ‘tyranny of distance’ faced by rural high school students when applying to study medicine at university. As Rural High School Liaison Officer for SPINRPHEX Georgia along with GP’s, medical interns and other undergraduate medical students visited numerous rural high schools in WA. Three hour workshops, confidence training sessions and dinners were held in order to encourage and support rural high school students (Years 11/12) hoping to study medicine at university. Information from these visits was used to develop the ‘Choose Medicine’ website.

The website is designed to be a one-stop-shop for rural high school students interested in studying medicine. It provides information on how to apply to university, links to every medical school in Australia, profiles of medical students who have come from rural backgrounds, information about scholarships, bursaries and Centrelink payments, details of university life, chat forums and feedback forms.

The future potential exists for feedback received on the site to be used by researchers and course developers when considering rural high school student enrolment in medical degrees. By using technology to broach the gap the ‘Choose Medicine’ website has the potential to be a national solution to the national problem of rural high school student recruitment.

So you think it is a world away?

Bruce Seidel, BREAATHE

Bruce shared his enthusiasm for life in rural areas with a presentation on his experiences of life the Pilbara. Before entering university to study medicine Bruce lived and worked in the Pilbara region. He related the pros and cons of living in a small community as he saw them;

- The often lack of privacy vs a very active social life, community bbqs and fun days
- A safe and active environment to raise young children vs very few choices in high schooling.
- Fewer choices in shops and amenities vs close locality to an untouched natural environment, beaches, waterholes and spectacular canyons.

He also took the audiences breath away with photos of the magnificent Pilbara landscape, the untouched natural environment he described as one of the biggest draw cards for living and working in the region.

Studying Nursing in a Rural Setting: Are Students Adequately Supported and Prepared for Rural Clinical Practice?

Lyn Gum & Terri Minge, Flinders University.

Lyn and Terri presented the findings of research conducted to explore the adequacy of support, preparation and retention and recruitment issues as experienced by the first cohort of Flinders University Bachelor of Nursing students at the new rural clinical school in Renmark.

The research was conducted in the form of online surveys and whilst being utilised by university course developers also reveals issues in relation to the shortage of nurses in rural areas.

Of the 19 students in the initial cohort eight students completed the surveys. Half of these were in the 18-39 year old age bracket with the remainder being in the 40-59 year old bracket. Respondents were predominately women and of varied marital status.

Of the 8 respondents 5/8 felt prepared for practice, shift work and care-planning but 3/8 felt inadequately prepared for the application of pharmacology.

5/8 students felt well supported by the local clinical staff but not by University academic and administration staff in Adelaide. The majority felt that they were well supported in their studies by family and friends but financially unsupported by the government/university/scholarships.

The research reflects the communication difficulties many students in rural clinical practice experience and the lack of financial support provided.

Students also commented that because their course was condensed into two full days of study, with no alternative lecture/tutorial times that missing a day of study was like missing a whole week.

Concurrent Paper Session B Report by Leigh Dahlenburg

After Hours Triage - Meeting the Needs of SA Rural Communities, GPs and Nurses
Ms Jenny Fleming and Dr Karen Sumner Rural Doctors Workforce Agency

After hours care is a recruitment and retention Issue for the rural medical and nursing workforce and is essential to address for the long-term future of the rural and remote workforce in Australia. Many rural GPs in South Australia utilise the local hospital nurse triage system for after hours service provision, however many nurses in SA have reported that they don't have appropriate

training and often lack confidence in after hours triage. In addition to this, there is currently no specific rural nurse triage training program in South Australia. The After Hours Triage Training and Education Program for Rural SA is an initiative of the Rural Doctors Workforce Agency (RDWA), funded by the Commonwealth Department of Health and Ageing (DHA). This 2 year Program aims to improve communication links between rural GPs and after hours triage nurses as well as providing triage training for rural hospital nurses. After Hours Triage Training Workshops have occurred in 23 rural communities throughout SA involving over 100 rural General Practitioners and 160 rural nurses. Workshop participants reported its great value and benefit particularly in facilitating communication processes between local service providers (rural GPs, nurses and hospital administrators). Nurse participants have reported an increase in knowledge, skills and confidence in all aspects of after hours triage covered in the Program. An outcome of the Program will be the development of a transferable and sustainable training resource that will be available to other hospitals/communities in rural SA and Australia. SA

Bringing the Bush to the City: Using e-mentors to Link Medical Students with Rural Health Professionals

Dr Tarun Sen Gupta, James Cook University.

In initiating its rurally oriented 6 year medical degree in 2000 James Cook University Medical School faced the problem of ruralising a metropolitan campus based degree.

The solution? Linking students of the second year Rural, remote, Indigenous and tropical health subject with mentors (health professionals including nurses, allied health professions and Indigenous health workers) currently working in a rural setting.

Students are required to complete a variety of tasks from developing a profile of community health needs to assessing recruitment and retention issues. The mentor acts as a direct resource and a conduit to other community resources. Most of the communication occurred via e-mail and telephone. The aim of the subject is to provide students a real world context that they can apply their learning in.

Initial and on-going evaluation of the subject provided a few key recommendations:

- Students and mentors should be carefully matched
- Many mentors did not have regular or reliable access to the internet or required internet training. They also needed to be prepared for what was required of them as mentors
- Students needed to be considerate of the times they contacted their mentors and appreciate that mentors would not always be immediately available and that communication guidelines should be developed.

Overall, both students and mentors reported the learning experience as being positive, with many mentors volunteering to assist in following years.

MAHRS: A rural Health Club at a Rural University and our Presence in the local Community.

MAHRS is one of the few Rural Health clubs solely situated in a regional centre.

This means that the way we co-ordinate tertiary students involvement within in the local community is unique. In fact it is imperative. The past twelve months has seen a number of initiatives eventuate to strengthen how effectively we promote rural health to student and the broader community. This paper aims to outline the steps MAHRS is currently taking to facilitate the needs of a uniquely rural student body.

Issues surrounding rural health affect every student studying at our campus. Because of this, MAHRS has become the overarching support mechanism for all allied health students. A number of projects are currently underway to encourage interdisciplinary understanding and professional development within our student body.

A priority in strengthening awareness and understanding of students' needs has been direct liaisons with higher bodies within the university. Our rural high school visits initiative has been strengthened by cross involvement with the prospective students' office and local and state youth careers promotions. We aim in the next six months to launch research into just how effective youth careers events such as RHSV are in compelling rural students to pursue health.

We are also actively forming closer ties with NSW, VIC and TAS clubs to provide direct support for students on interstate placements.

We feel that sharing how MAHRS facilitates the total rural demographic of allied health at CSU Albury/Wodonga will give other clubs an insight into the importance of community presence.

A Sustainable Approach to Undergraduates in Rural Placements

For the first time, rural health is being recognised as a specialist area of medical study. In a well-established speciality, there is a conventional method to introduce medical students to the field. There may be guidelines provided by the university. The teacher may have their own memories of the subject in medical school.

For rural health this is not yet so. The face of rural health, and the teaching of it especially, has changed so much over the past few years that the structures in place are no longer adequate. There are more students doing rural rotations, the students have different goals, and the medical issues have changed.

Early this year, the Rural Medical Education Victoria conference was held in Melbourne. It was intended to address the challenges arising from the current state of rural medical education. Based on the recommendations from the conference, the current state of affairs of rural education in Australia and the experiences of medical students, there are several areas that need to be considered. The first is the image of rural health. The experiences of students on rotation, the type and quality of the teaching, and the student's relationship with the doctor all contribute to this.

The quality of the student's experience depends on the support that they and the doctor receive. Possible sources of support include the universities, the community and government.

Finally is the content of the curriculum. Things such as the multi-disciplinary team that the doctor works with, the way in which the community works and the way that the doctor fits in to the community are all important, but difficult to teach. A consensus on what should be in the rural curriculum would benefit rural health.

This is an exciting time to be involved in rural health. The decisions that we make now may change the shape of rural health for a long time to come.

Concurrent paper session C
Report by Lenore van der Merwe

Embracing indigenous communities and creating a specialised health work force.

Alex Bennet, LARHC

Alex is a 4th year Pharmacy student at La Trobe University and is the chair of the Rural and Indigenous subcommittee for the National Australian Pharmacy Students' Association (NAPSA). He has a keen interest in getting students involved in, and exposed to indigenous health care at an undergraduate level, and his talk aimed at encouraging students to undertake placements in indigenous communities through sharing some of his experiences.

Last December, Alex did a placement in an Aboriginal community on the Tiwi Islands, and found it to be an incredibly worthwhile opportunity to learn first hand about the issues facing indigenous people, which he had only learnt about in theoretical terms before then. He told us of his experiences living in the community amongst the people, learning about their culture, and joining them in their rituals and hunting, which he felt had had a tremendous impact on him both personally and in terms of his future career. He conveyed a huge amount of enthusiasm and encouraged other students to get out there and share the experience. He also stressed to allied health students that while most communities do not have resident allied health professionals to mentor them, they would still benefit greatly from the undertaking placements under the supervision of health professionals in other disciplines, and that working as part of a multi-disciplinary team would add to the experience.

The talk raised awareness about the opportunities out there for gaining exposure to indigenous communities, especially for allied health students, and also of the benefits that such exposure can provide to students. I am sure Alex has motivated many to consider doing some of their prac in an indigenous community.

A community-based approach to supporting rural and remote indigenous students in the health disciplines and promoting careers in health.

Ms Maree Adams, University of South Australia; Ms Marilyn Coulthard, student at Pika Wiya Learning Centre, Port Augusta

This presentation focused on the Pika Wiya Learning Centre in Port Augusta and its approach to providing culturally appropriate education to indigenous students, using it as an example of a practical approach to dealing with the problem of the low recruitment and retention rate of indigenous students in tertiary health courses.

The centre is a community-based and controlled learning facility for Aboriginal students studying tertiary health courses, which has sought to address culturally inherent barriers faced by rural indigenous students, such as a lack of role models, the unfamiliarity and cultural relevance of the university environment, community and family pressures, and a lack of support and encouragement. It aims to provide culturally appropriate learning and support on an academic, personal, peer, social and administrative level to retain students and help them progress through, and finish, their studies and then continue into employment. Through this approach, they hope to foster amongst students knowledge; pride in themselves as individuals, and in their families; greater self-esteem and confidence; higher aspirations, and a sense of community ownership.

The "success stories" of some of the students who have studied through the centre were related, and Marilyn, a mother of 2 in her final year of studying to be an enrolled nurse, also shared something of her experiences as a student at Pika Wiya.

This talk presented an interesting and thought provoking profile of a unique centre of learning, which has much to offer as a model for community-based, culturally appropriate training of indigenous health professionals.

Are you talkin' my lingo?? A resource for occupational therapists working with Aboriginal people in Tamworth.

Erin Cameron, BREATHHE University of Newcastle

Erin is a fourth year occupational therapy student at the University of Newcastle, and has been undertaking her final year in Tamworth, in the New England region of NSW, which services the largest proportion of Aboriginal people of any rural health service in NSW. Upon starting out there, she was struck by the need to adopt a different communication style/strategy, which was sensitive, appropriate and, moreover, specific to the Aboriginal people of the area in order to obtain and impart information in an efficient and meaningful way.

She felt that her training had not equipped her sufficiently with awareness and skills to overcome these cultural barriers, and that there was a need for a training programme or educational resource which could be made available to health care workers (specifically occupational therapists) starting work in the area. For her honours project she has created such a resource in consultation with the Aboriginal community of Tamworth, which she hopes will promote more effective communication and collaboration, and further the development of rapport, providing better client-centred Occupational Therapy services to Tamworth's Aboriginal population.

Her project will, no doubt, serve as a valuable educational resource to health care in the Tamworth area, but also as an excellent model for similar resources in other rural areas and indigenous communities.

Are we in the right forest? The 'realities' of remote indigenous health practice.

Assoc. Prof. Janie Smith, James cook University

Some of the many issues in rural, remote and Indigenous health were presented, in conjunction with some very eye-opening statistics and demographics. Attention was then drawn specifically to how these translated into issues for the health workforce, not only in terms of barriers faced in their provision of health care to aboriginal communities, but more specifically in terms of the inappropriateness and inadequacy of health services, and funding and policy to address the well-documented, and yet persistent, social determinates of the appalling health outcomes of remote-living and Aboriginal people in Australia.

Janie's "Social Justice" perspective on the realities of remote and indigenous healthcare was sobering and highly thought provoking.

Friday 1st October

Keynote Speaker - What the People Want – Delivery of Health Services in Rural & Remote Australia

Assoc Prof Lorraine Shepherd, University of South Australia School of Health Sciences

Report by Tim Starkey

Prof Shepherd began her address by stressing the importance of the delivery of health care to rural and remote Australia, noting that it is an issue that is always on the political agenda. Despite this, it is an issue that has not been addressed satisfactorily and there is much work to be done to arrive at an efficient and sustainable system of health care.

She presented the Healthy Horizons program, which is an attempt to correct and improve some of the perceived shortfalls in current rural and remote health care. This focuses on primary health care and public health, which is accessible and flexible, and uses intersectoral coordination and multidisciplinary practice as well as consumer participation to provide enhanced community capability. The breakdown of goals in this program involves making the greatest health concerns a priority, a focus on ATSI health, promoting research and providing flexibility with a needs based funding and workforce. This incorporates a 'whole of health approach' considering lifestyle, environmental and physical factors.

Prof Shepherd continued by pointing out the issues with the current health system which is under stress, requiring an increasing budget and focuses on ill health as opposed to maintaining good health. There are changing population profiles and social determinants, which result in a changing burden of disease. There is also a great mix and difference in the distribution of services and fragmentation and duplication in planning, funding and governance.

This introduction led on to discussion of the Generation Health Review, which has identified several areas that need improvement. The key themes from the Review were:

- A population health approach focussing on geography, health funding and statewide planning
- Primary health care with networked and integrated services with statewide referral hospitals for complex services.
- Accountability and transparency within the healthcare system allowing access to information, community involvement and safety and equality for all.
- A streamlined workforce with new ways of working featuring crossover of jobs.
- Health as a right for all.

This review and these ideas have significant implications for the workforce. Those in the industry will have to respond to new ways of working, participate in workforce planning and have community involvement. In practical terms there will need to be integrated and easy access.

Functional integration calls on 3 areas:

- Governance – Involving networks and having primary care available close by.
- Technology – Shared communications and shared protocols.
- Transport – Readily available to allow service access.

Examples of service models of this nature that are already in place are the Northwest Queensland Allied Health Service based in Mt Isa and Katherine Remote Allied Health and Therapy. These models are multidisciplinary with a move away from solo practice to team practice, are flexible, focus on priority health problems, involve outreach services and employ local residents for community support.

Prof Shepherd then addressed the issue of who should be delivering these services and what the future holds. The shift to see rural and remote medicine as its own specialist discipline is important whereas it has previously been viewed as a generalist area. Key organisations in promoting this are ACRRM, CRANA and SARRAH. Specialities within existing professional bodies also have a role of promotion here. In the near future, the Professor sees improvement in the total determinants of health and more research and evaluation as key areas of progress. Among the total determinants, more use can be made of the existing built environment, more can be made of opportunities for health screening and lifestyle factors affecting health status can be improved. The view that rural and remote medicine is a distinct specialty and not a conglomeration of general and specialist services must be encouraged. Research and evaluation needs to be carried out into the provision of common networks and protocols to improve the efficiency of service provision.

Prof Shepherd concluded her address, wishing the delegates well for their future careers together and suggested skills that are important for future practitioners of rural health. These skills include:

- An ability to determine population health issues
- Encouraging community involvement
- Teamwork
- Communication
- Evaluation

Concurrent Paper Session A

Report by Alannah Smith

Increasing Pharmacy Awareness – Your Rural Pharmacist

Georgina Lippis (RUSTICA) and Trent Twomey (RHINO)

Rural pharmacists are generalists and provide many services. They are experts on drug choice and management, are crucial to a rural community, provide a variety of services, collaborate with other health professionals and are often the first port of call (eg in minor complaints).

It's important, that with such an important figure in the community, that people are made more aware of pharmacists and their roles, so that they can be fully utilised. This will lead to improved health care in the community. The rural pharmacist can act as a triage of the health care team and as a community leader.

The average rural town has 1-2 doctors, a hospital with 20 beds, few allied health workers and a general lack of health professionals. The health of people in these rural and remote communities is of a lower standard. The community does not take full advantage of pharmaceutical services – they perhaps don't realize services and the knowledge that a pharmacist can provide. Thus, if the patients' awareness of pharmacists and their roles is increased, then health outcomes will also be increased.

These thoughts lead to the development and implementation of PPAC (Pharmacy Profession Awareness Campaign). This is an initiative of IPSF and has been adopted by NAPSA. NAPSA is a federation of its constituent organizations (COs). Two national councillors are appointed for each CO. NAPSA facilitates communication between the entire COs. The four aims of PPAC were to:

- Inform the public about pharmacists' roles
- Inform other health professionals about pharmacists' roles
- Make people aware that pharmacists are the experts on drugs
- Raise awareness of pharmacy as a career at secondary schools

During a campaign, a qualified pharmacist is present, as well as pharmacy students from 1st to 4th years. The following activities are undertaken, as examples of what pharmacists do: Blood pressure testing, blood glucose monitoring, weight management information, Self Care cards and bone density testing.

So far, PPAC has been run by TAPS in Launceston, Hobart and at Agfest. NAPSA aims to have had every pharmacy club complete a campaign in the near future. Initially, PPAC aims to be run in all metropolitan and regional areas, and then move further out into rural and remote areas.

“Most people I know, think that I'm crazy...”

Erin Cameron, Jenny Norris (BREAATHHE)

Erin's Perspective:

Erin moved from Newcastle to Tamworth for whole of 2004 to study OT. She had had 3 years on campus, which was very social and action packed, and decided it was time to move on.

The accommodation was good, and she was sharing with a medical student, and then later a 4th year OT student. Some of the changes that occurred were that university became the hospital, and she was able to choose a seat. Erin was able to be part of the lectures via a video conference in a lecture room in the UDRH building.

The negatives of this experience were the loneliness: being the only OT student. All the other students were medicine students, and they were very close knit. There was very little interdisciplinary socialising because of this. But this allowed for more work and less talk.

The positives were that Erin could take in a cup of tea and biscuits into her lecture and she could mute the microphone and have a chat as she pleased. Erin was also fortunate to have access to a senior OT lecture Dr Rod Cooper, she also had the support and encouragement of staff. This support helped to further develop her networking and socialising.

Jenny's Perspective:

Jenny had previously lived near Tamworth, so moving from Newcastle to Tamworth allowed her to be closer to home. She joined Erin for 2nd semester. The positives of this experience were that she developed greater confidence in her clinical skills, her job prospects improved, she increased her networking with local OT staff, and she gained insights into rural practice.

The challenges were the video conferencing, and that Jenny was one of a minority, which could sometimes cause social isolation. This meant that Jenny took many trips back to Newcastle.

Jenny found that this experience gave her greater flexibility with her timetable and that she had the lecturers all to herself, which allowed her to obtain more assistance with her studies. She also had access to free photocopying and printing. In general Jenny found that the experience provided her with valuable rural practice opportunities.

What rural General Practitioners are Telling Us: Getting the Infrastructure Right for Sustainable Rural Undergraduate Programs.

Mrs Judith Walker University of Tasmania

Currently there are approximately twenty 5th and 6th year medical students, as well as pharmacy and nursing students, at Tasmania's Rural Clinical School in the north-west of the state. This number will increase but it's important that the infrastructure is right for this to occur. The rural clinical school offers an integrated rural and remote undergraduate clinical program for the last two year of the MBBS course. Medical students can gain experience and clinical training in medicine, paediatrics etc. The aim is to prepare graduates that are able and competent to work in rural and remote areas.

In developing the infrastructure for the rural program, emphasis was placed on ensuring a balance between hospital and GP/Community training. This was completed at the rural clinical school, in association with the local division of GP practice. The north-west Tasmania Division of GP acted as a broker between rural clinical school and each GP practice.

The rural clinical school recognised the contribution of GPs and their practices to clinical teaching, and provided financial and in kind support to those practices that participate in the program. The

rural clinical school provides, to each practice, library resources, a set of diagnostic instruments for students, a desk and chair, and they cover telephone costs.

Two GP academics support each practice and provide locum service to support the teaching as required. Participating practices receive financial support to cover part of the costs associated with provision of clinical teaching.

The impact of this program on the GP community was determined via a questionnaire six months into the program. It was found that GPs noticed big changes by having same students return each week and that they saw the long term benefit of program in workforce supply.

Preceptorship/Mentorship; The Graduate Nurse Program: A Rural Perspective

Miss Christine Chiengantambu RN, Lecturer/Clinical Facilitator The Adelaide University

From a rural perspective, there are shortages of nurses, and there are many personal issues that are involved in practicing in a rural area. These include family commitments, sick leave and personal crisis. The nurses also find that they need to be multi skilled in a rural area, and that there are rostering issues. It was found that graduate nurses experienced shock with entering practice and that they required clinical and professional support.

The preceptorship model is based on a one-to-one relationship and the mentorship model is perceived as an advisory role. Both preceptorship and mentorship are very important and their meanings have been 'meshed up and their roles mixed. This affects the way that support can be given to the graduate nurses.

The program, called GNTP: Graduate Nurse Transition Program, was run initially in Port Pirie Hospital. It was found that the nurses wanted clinical support within the first few days, rather than professional support. GNTP involved a one week orientation program. This program offers in-service workshops: both in house, and in other facilities. Initially there were 10 graduate nurses entering this program, and then this had to be lowered to 6 due to funding cut backs.

A model of preceptorship was developed to support the novice Registered Nurse. This included clinical and educational support. Interim and end of placement reports were also required. This was to enable professional development, for example, if something goes wrong, the preceptor can help the novice RN to improve it and resolve any issues.

Preceptor and preceptee shifts needed to be synchronised to provide consistency: there needed to be a core preceptor. Despite this, the preceptor can be absent, as long as a replacement is present. It was found that this was mostly a positive thing, which enables the graduate nurses to gain clinical skills and practice from a variety of nurses. Support was provided to the preceptors with thank you notes, and cheese and wine evenings.

Concurrent Paper Session B Report by Katie Maver

A Different View of the Rural Health Landscape, Assoc. Prof. Janie Smith, JCU.

The "Realities" of Remote Indigenous Health Practice

Assoc Prof Smith highlighted to us the unique problems associated with the delivery of health care in remote indigenous communities including limited access to health care, isolation, poor communication, poor living conditions, lack of basics such as reliable electricity and water,

differing cultural perceptions and practices, and limited understanding of western medicine. She illustrated this with the story about the struggles of Stella and Rob, a typical Aboriginal couple. She emphasised the need to challenge people's ideas and pre-conceptions. The story of Stella and the difficulties she experienced, including her troubles accessing healthcare during a complicated pregnancy and the extreme impacts this had on her and her family, really brought home the differences between general urban and isolated Aboriginal communities.

Stranger in a New Land, Beth Russell, AURMS.

Beth shared her experiences working to deliver health care in a rural Aboriginal community. She took a year out of medicine to work for an organisation whose aim was to address the big issue of malnutrition and "failure to thrive" in Aboriginal children. A council of aboriginal women headed the program, with a group of non-aboriginals to help with organisation and administration. Beth was paired with a local Aboriginal lady. By placing the operation of the program in the hands of the Aboriginal elders they hoped to succeed where other non-aboriginal run programs have failed. Cultural barriers often ruin the most well planned programs. The program had three parts; treating children suffering from malnutrition; teaching their mothers about malnutrition and proper nutrition; and promotion of good food practices and nutrition amongst the community. It faced many barriers, cultural and societal, dietary habits are hard to change and nutritious food is often hard to come by or very expensive in these communities, although the program did have some success where others had failed. The program is still going.

Kempsey and Back Again: Indigenous Health Through Personal Experiences, Nicholas Moore, RAHMS

Nick, along with RAHMS president Rob Scott, talked about a rural trip they organised for health students from NSW. Their aim was to give students a positive personal experience of rural Aboriginal culture, life and health. They had noticed a lack of Aboriginal education in their course. The trip was done on a tight budget, it involved a bus trip up the coast to an aboriginal community, a rural high school visit, half a day with an Aboriginal elder and his family teaching about Aboriginal tradition and cultural and other social and cultural activities. The dates were carefully picked to allow a cross section of all the years and courses to attend which took some effort; the trip was from a Thursday arvo to Sunday with the students given permission to be absent on the Friday. The trip was a great success educationally and socially with future trips planned.

Health in the midst of other complexities: Discovering another side of Australia, Angela Titmuss and Laura Stephenson RAHMS/TROPHIQ

Angela and Laura participated in a Saint Vincent De Paul school holiday program run in a rural Aboriginal community. They found it interesting being involved in an Aboriginal community outside of a healthcare setting. They asked: how can a problem be described as purely health when so many other problems such as education and poverty contribute to it? Boredom is a huge problem in these rural areas and it adversely affects the health of children who get involved in dangerous alternative activities. Simple things like school holiday programs can help the health of communities. They felt that the social determinants of health were not recognised by universities etc. Other factors influencing health such as lower education rates are also evident in rural areas. Health clinics are an important part of addressing the rural health problem but they are not a cure, the problem is much bigger.

Concurrent Paper Session C

Report by Katie Walker

Just ring 1-800-RURAL-HEALTH

Anthony Zirilli and Angela Willis (WARRIAHS)

Anthony, the WARRIAHS President for 2004, presented this informative and humorous paper. The presentation was focused on what studying rural can offer, and the fact that the quote “study rural, study rural” has a real basis. In addressing the question of “is rural health sexy”, they chose to discuss rural health in the context of a number of words with sexy connotations. Here are just some of the examples that were presented to illustrate what rural health can offer.

Rural health is “provocative” due to the opportunities that present in which socializing can take place between health fields and university’s – as is the case at NURHC.

Rural health is “seductive” due to the fact that money is sexy, and a wide variety of rural scholarships are available to students studying rural health.

Rural health is “sensual” as health students share a mutual understanding of the struggles and difficulties faced in rural areas. This understanding also extends beyond the health disciplines, to Agriculture students who are situated in rural areas. There is the real possibility of a health and an agriculture student to find love!

Rural health is “enticing” due to the small class sizes offered, and the sense of family between the students situated at a rural clinical school ensures that lifelong friends are made. There is also the benefit that the lecturers and doctors know the students by name and learning is on a personal level.

Finally, rural health is “beautiful” due to the idyllic lifestyle that is offered to rural students. The country is smog and traffic free, with open spaces, and local communities are welcoming and friendly.

Graduate Assistance & Partnerships Program (GAPP): Providing support, information and advocacy for rural health graduates.

Ms Simone Bartrop (GAPP Project Officer, ARHEN)

This session aimed to give students an overview of the Graduate Assistance & Partnerships Program (GAPP), focusing on what it can offer later year students during their transition into the workforce. The interactive website for this program can be found at www.gapp.org.au. GAPP is a national multi-disciplinary support program for health students. It is an NRHN initiative and is in its early stages with a pilot program that has been initially funded for 2 years, until December 2005.

The key objectives of GAPP include maintaining graduates interest in rural health issues, to facilitate peer support and discussion on rural health issues, and to allow graduates access to a professional mentoring program. GAPP also aims to encourage members to return service to the rural health clubs by returning to offer mentorship to students, and to provide data regarding the impact a previous University rural health club has on graduates.

Currently GAPP has 45 registered members. Its biggest challenge faced is recruitment of members and making the network active and enthusiastic. The session was focused on encouraging later year students to become members ready for their coming years when they make the transition into the rural workforce.

The “Blank-Look” Health Profession

Ruth Hosking (TROHPIQ) and Louise Andrews (LARHC).

Both girls are combined nursing and public health students, and Louise presented this paper on behalf of Ruth who was unable to attend. The aim was to address the stigma associated with being a public health student by providing some information into what public health students actually do. Surveys undertaken within both their rural health clubs showed that perhaps people are not so “blank” about what public health is, but more often find it boring.

Public health is a multi-disciplinary set of activities aimed at the protection and promotion of the health of communities. Issues commonly faced by these students and professionals include lack of resources, difficulties in getting the information out to communities in need, and a lack of public health professionals in rural locations.

Public health is focused on prevention and epidemiology, including the rate and spread of disease. Every day other health professionals implement strategies into their own practices that were recommended by public health professionals. A major downfall for public health students and professionals alike is the lack of recognition received, patients are unaware of the work they put in and the positive impact they have on the health of communities.

Social Report

Tuesday Night

Report by Ashlie Hill

Tuesday night, our first night at NURHC consisted of a quiz night and other games such as ‘phone number bingo’. Everyone was tired after a long day of travel (for many this included two plane trips with a long wait between, and then the 90 minute bus-ride from Adelaide to the Barossa Valley!) but excited about the week that lay ahead. Everyone was encouraged to mingle and separate from their state groups, so this was a great chance for a ‘getting-to-know-you’ session. The quiz included nine rounds with topics as diverse as health, pop culture, music and sports, as well as a bonus round conducted by the bus drivers about road rules and characteristics of coaches! All-in-all it was a good night. There was a relaxed, but anticipatory feel in the air. I personally made a couple new friends with some people at our table, even if we did spend a ridiculous amount of time debating the weight of a bale of wool. This was a good start to the week.

Wednesday night - Pyjama Party

Report by Matthew Spotswood

This event was viewed with trepidation by some, with the embarrassment caused by having to cross Main Road Tanunda in broad daylight while wearing pyjamas being cited as the main reason. Upon arrival at “the tent”, as the dining hall quickly became known, we realised however that everyone had indeed come out in their sleeping attire, and were ready to enjoy themselves. The enjoyment of the evening was facilitated by the fact that the social committee had decided not to supply free grog, but had instead opted to provide all the fun of the fairground; a whirly bird ride, sumo-suit wrestling, rock-wall climbing, tattooing, and the greatest delight of all: fairy floss. If the carnival atmosphere outside wasn’t to your fancy, there was also the dance floor inside the tent, giving you the opportunity to gyrate to all your favourite tunes, while losing the use of your ears. The soon to become apparent tolerance of the bar staff at the Tanunda Hotel was tested for the first time at

NURHC when 30 or so delegates decided to continue the pyjama party at the only pub in town. A good night was reported by all of those delegates who managed to get more than 3 hours sleep.

Thursday Night

Report by Alannah Smith

Thursday the 30th of September was our multicultural night at NURHC. This was where all the different states, and New Zealand, dressed up as certain countries, such as, Antarctica, Asia and Europe.

Rustica, along with our friendly neighbours, New Zealand, dressed up as Australians. This was met with much team spirit and enthusiasm as we dressed up as lifesavers, Tassie Devils and the farming type (notably Shazza, Chezza, Kazza and Jazza). Everyone put in their best efforts with short shorts, bondsies (or 'wife beaters'), flannies, hats with corks, and most importantly "Aussie, Aussie, Aussie – oi, oi, oi!" This was our token chant with which the whole marquee would soon become accustomed to.

The night was a "bloody ripper mate" with a belly dancing performance (which unfortunately Eddie was not able to get involved in), flamenco dancing and folk music. A modelling competition followed where Rustica put on an outstanding performance that involved Eddie drowning and the lovely lifesavers coming to rescue him.

This night was a fabulous night that allowed everyone to go crazy getting dressed up, as well as enjoy the variety of entertainment that was performed.

Friday night – Formal dinner

Report by Sarah Donoghue

Following the conclusion of the academic side of the conference, excitement broke out as preparations began to transform the average student into the beauty of the ball! Quite a few Rustica members began with a quick winery tour to sample the delights of the Barossa, it would have been wrong to leave without immersing ourselves into this important cultural side of the community we had inhabited for the last 4 days.

On arrival at the dinner, the tent had been transformed into a glamorous ball room! We were treated to a sumptuous 3-course meal (wasn't that chicken just great!). Refreshments were those white and red delights from the local area, along with the local Coopers beer, and for some reason an unmentionable import from Qld. A DJ was on hand to provide ammunition for the dance floor, and it wasn't long until all delegates were carving it up and putting in their best dancing effort. Following the dinner, many kicked on to the Tanunda Hotel where the partying just kept going on and on until the early hours (resulting in some very tired looking people on the buses early the next morning).

A fantastic time was had by all. The night provided a final opportunity to spend a last few hours with our newly made friends, and say our sad goodbyes and promises of "same time, new place" next year!

Discussion Topic Reports

Maintaining Sanity, the student, the professional and Mental Health Issues in rural and remote communities

Report by Alannah Smith

This discussion topic was included in the NURHC 2004 discussion topic from recommendations from NURHC 2003. This discussion topic focussed on:

- An undergraduate perspective on mental health as it pertains to university curricula and rural placements.
- Community perspectives on rural mental health
- Maintenance of mental health for students and professionals
- Mental health as a concept of “wellness” rather than “illness”
- Mental health strategies at state and federal levels
- Opportunity for networking and developing new initiatives
- Practitioner issues and national practice standards for mental health
- Rural health club initiatives that promote mental health of communities and club members

This discussion topic began by an introductory speech from Dr Grace Groom, Chief Executive Officer, Mental health Council of Australia. The following day, about 40 people went to our discussion topic for an introduction on the aims of the sessions, what has been happening previously for mental health and a brain storming session on issues involving mental health.

We then put these ideas into broad topics and split off into groups to further discuss them. These topics included: stigma, survival guide, mentoring, placements and mental health. My topic was survival guide, and we focussed on this, and then presented our ideas to the larger group at the end of the session.

The following day, we were asked to put all our ideas on the survival guide into three or four achievable recommendations. Essentially, ours stated that:

- The NRHN should continue to develop the Survival Guide and that it should be accessible to all students.
- The Survival Guide should be an official document, which contains contacts for the student. An insert should be added for the Rural Health Clubs to add their specific contacts.
- The Survival Guide should be relevant to all health disciplines and to students of different backgrounds.

With all the groups' recommendations we determined that the key areas of importance were:

Online Support – at a national level, the NRHN needs to implement a national forum for discussion for rural and remote placements as well as student life and student's experiences. This forum may need to be anonymous. Also, a posting page could be established, whereby students can report on their placements.

Well Being – Promotion through RHC of well-being. This could be achieved using positive professional role models, emphasising self care and raising awareness eg through a poster campaign.

Liaisons – Clinical and community liaisons/social support should be available for all students on placements. The NRHN should also lobby universities including rural clinical schools to provide access to academic and community mentors/liaisons. Access to advice should be independent of supervisors.

Survival Guide – NRHN needs to continue to develop survival guide for health students.

National Standard Guidelines – To be developed and investigated by NRHN, they need to focus on university accountability.

Aboriginal and Torres Strait Islander Health and the Role of the Rural Health Club Report by Matthew Spotswood

This discussion group provided five recommendations:

1. To develop and maintain a sustainable database within a web forum of contacts and relevant information to ensure consistent and dynamic resources for rural and remote health clubs.
2. To clearly delineate the role of the ATSI rep. This should include a formal position statement of the ATSI rep. The requirement for an end of year report from rural health club ATSI reps is to be included in the formal position statement.
3. To produce practical information package available to all students interested in running Rural Health Club (RHC) indigenous health activities. This will include a summary card of the position of ATSI rep, and contacts and relevant information.
4. To raise understanding and awareness of indigenous health by inviting Aboriginal Health Workers (AHWs) to attend and participate as guest and keynote speakers in future NURHC and RHC activities.
5. To maintain interest and increased participation in lobbying for relevant issues associated with indigenous health as supported by the NRHA.

The first three of these recommendations are an attempt to improve the general knowledge of RHC members about ATSI health issues. They aim to provide information for ATSI reps to access, and to then pass on to their RHC members. They aim to provide assistance with organising ATSI health related events, and to give the ATSI rep some clearer direction on what their portfolio entails. The ultimate aim of these recommendations is to increase the recruitment and retention of ATSI students into the health professions by increasing general knowledge and awareness of ATSI health issues.

The fourth recommendation continues in a similar vein, by encouraging liaison with AHWs who can provide further insight into ATSI health issues.

The fifth recommendation is more general in its approach, and pertains to the NRHN as opposed to the individual RHCs. It recognises that the NRHN, as a part of the NRHA, has the potential to play a significant role in lobbying for ATSI health issues.

Discussion Topic: Understanding needs Report by Sarah Donoghue

Context: Needs are driven by a person's education, socio-economic status and environment. Health outcomes are closely linked to all of these, especially education.

This discussion topic was broadly defined with the aim of developing a paper with distinct objectives that could be achieved by rural health clubs. Barriers was the topic that I was involved in where we discussed barriers that people find in working with each other to obtain appropriate outcomes. It emerged during discussion that there was a feeling that we need to diversify rural health club membership and work more closely to understand each role in health care delivery. It was felt that this approach was needed in a rural health club for the future, and that it would enhance our participation in activities involving all things from rural high school visits to community participation.

The outcomes from my specific group in this session are below:

Recommendation

To enhance student interdisciplinary and intersectorial collaboration and awareness

Rationale

In order to improve health and extend our understanding of health it is crucial that we work to enhance the ability of the National Rural Health Network and individual rural health clubs to work in an interdisciplinary way and with a variety of perspectives. In the rural and remote setting, there are so many complexities affecting health which must be taken into consideration by health services. As an organization which has declared a strong commitment to Aboriginal and Torres Strait Islander health and improving the recruitment and retention of Indigenous students, the NRHN should support the inclusion of those studying to be Aboriginal Health Workers, community development workers etc (which are a crucial part of health services and may also be future university students) at future NURHCs and within rural health clubs.

Strategies

- **Multidisciplinary rural case scenario**
Incorporate a multidisciplinary rural case scenario into future NURHCs (eg. as a plenary or a skill session) or as a workshop at RHCs/RHSVs, outlining the role of each health profession for a patient (with some practical activities), and also a discussion of the influence of other sectors (eg. education, housing) The case studies could be placed on the web for RHCs, given as a simplified CD for high school students, and as multiple stations for NURHC (role of 3-4 professions covered at each station, try to represent each RHC at each station).
- **Non-health keynote speaker at NURHC**
Have a person of a non-health professional background to be a keynote speaker at future NURHCs, broadening our understanding of health. Examples of possible speakers include a community development worker, a consumer, education, media (eg. Jeff McMullen)
- **Diversify NURHC constituent population**
Diversify NURHC constituent population to include Aboriginal health workers, community development workers, not-for-profit organizations, TAFE health students etc. This might require seeking sponsorship from other institutions responsible for training of AHWs, enrolled nurses.

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Recommendation

To assist students and future health professionals in gaining the skills in community collaboration, consultation and communication necessary to understanding community needs.

Rationale

The 8th NURHC drew attention to the importance of health professionals understanding community needs, working together within a community controlled model, using existing resources and undertaking community education. In order for this to happen, the NRHN has identified that students, as future health professionals, require more training on how to undertake community collaboration and consultation.

Strategies

- **Community consultation skills session**
Incorporate a skills session at future NURHCs on how to undertake community consultation, possibly using an example of a consultation undertaken in the host area.
- **Community development workshop**
Workshops and/or speaker nights by local NGOs/community development workers on how to discover community needs and undertake consultation. NGOs could be asked to share some of their resources (eg information sheets, summaries of projects such as the Animation Project in SW Sydney) and provide some simple training. When visiting rural communities, RHCs could incorporate talks with local organizations who regularly undertake these need appraisals or who work to meet perceived need, so as to move scenarios into a rural reality.
- **NRHN booklet**
Include an 'Understanding Needs' component in the NRHN Rural Health Club Booklet, with a short summary/guide to community consultation and a practical example aimed at student level. (see appendix)
- **Community profiles**
Web-based community profile discussion and profile sites – publicise awareness of existing sites in NSW that profile various towns and seek out information about sites in other states. Provide links to these sites from the NRHN web page. Develop standard form for students (eg use AMSA or WA medical school elective models) to take on placements and detail demographics, current services and facilities, recreation activities, community groups, personal reflections, their level of preparation for the placement. If these were linked to state club websites,

then other students could access this information when traveling to the same location. In future, may also be able to link to NRHN site.

- **Placement opportunities**
Rural health clubs and University Departments of Rural Health to integrate opportunities for participation in current community consultations into placements and university curriculum.
- **Improve links between RHCs**
Improve links between rural health clubs using liaison officers, invitations to meetings, co-hosted events and web based discussion sites (increase use of existing NRHN discussion forum)
- **Broaden understanding of health**
Broaden the understanding of “health” in terms of understanding community needs eg. lobby university for curriculum change, integrate different perspectives into PBLs, RHC speaker nights incorporating other sectors

Recommendation

To empower rural and remote communities by working with individuals and groups, mobilizing resources to improve autonomy and sustainability of community well-being and building more productive relationships.

Rationale

Improving collaboration with rural and remote communities is an important part of rural health club functioning and will better prepare health students for the realities of living and working in rural communities. Empowering young people in these communities is particularly important in meeting future workforce needs across a range of areas and providing sustainable programs with a wider scope and target group.

Strategies

- **Develop a peer education model to RHSVs**
Develop RHSVs to incorporate peer education, empowering these school students to support and provide a resource for other students. This improves sustainability of the program, reaches a wider group of students, helps in accessing marginalized groups, and is probably more influential as is student oriented. Multiple students are required so that students do not feel isolated or uncomfortable.
This requires a committee that would be interested in developing a suitable program and seeking out existing resources and similar programs. Students with the skills to motivate and peer influence would be provided with information about rural health careers, scholarships etc and trained and supported to provide this information to other students, promoting careers. This takes the RHSV program beyond reliance on careers counselors or face to face visits by university students, and can empower school students to support each other and achieve their goals. RHSVs could also widen in scope to incorporate health promotion activities, using a similar peer education model.
- **Increase involvement of parents in RHSVs**
Parents can not encourage and support their children unless they know what options there are and how students can be supported through training pathways. It can be difficult for a student to pursue their interest in a health career without a parent who acknowledges and understands that it is not an unrealistic dream. Some students will not even consider the idea as they think their parents won't approve.
- **Rethink scope of RHSVs – incorporate health promotion activities**

Career counselors can sometimes restrict publicity of RHSVs to those students they think are suitable. A possible method to overcome this limitation is by widening the scope of RHSVs to include health promotion. University students are in the key position of being able to engage with school students regarding mental health, drug education, and other issues as we are so close in age and come with a different relationship. This might also make some schools more encouraging of RHSVs and could be continued using a similar peer education model to that outlined above. There are some recent examples of uni health students undertaking programs like this in the asthma area.

- **Increase publicity of the NRHN and RHSVs to career counselors**
Identifying a central meeting of career counselors on a state or national basis would be useful, so that the NRHN could address this meeting and describe the purposes of RHSVs and what supports are available for a wide range of students. Coming from a rural area need not restrict people's dreams.
- **Buddy program between RHC members and rural high school students**
Develop a buddy program between rural health club members and interested students in rural and remote high schools. This aims to improve motivation and support, increase recruitment back to rural areas, and empower students to later become a mentor themselves. The NRHN could contact James Fitzpatrick re his project and identify potential for partnership with this existing project.
- **More effectively target students from marginalized groups**
Improve rural health club liaison with school recruitment officers so as to improve recruitment, retention and involvement of students from marginalized groups. (eg. more clearly explain support services available, range of scholarships etc)
- **Improve interaction and networking of RHCs with local communities**
Sending out RHC newsletters to local councils, community organizations (eg. Lions, Scouts, YWCA, charities, sports clubs), MPs, farming organizations, media etc is a simple way to assist in their knowledge and awareness of RHCs and may also help to target young people from marginalized groups or those who are not easily accessible at school. It may also lead to more productive future interactions with these communities. When visiting a rural area, undertake RHSVs but also try to have some kind of interaction with young people that is not education based (eg. contact the local sporting club, drop-in-centre) to increase the number of young people reached. RHCs could also send an information sheet about themselves and with contact details to local communities organizations.
- **Improve curriculum input**
Rural health clubs role in monitoring and providing input for curriculum and increasing information on community empowerment and cultural awareness, providing a more supportive environment. Discussion at future NURHCs as to how students can influence curriculum, develop better academic partnerships etc would also be beneficial so as to upskill RHCs (eg. a discussion with academics regarding university curriculum processes).
- **Increase involvement of marginalized groups**
Increase involvement of individuals (students and non-students) from marginalized groups at NURHC and in RHCs, providing a greater range of perspectives and supporting these individuals to share their understandings of community needs. It is important to engage people in all aspects of NURHC, in discussion groups, as speakers, as delegates). It would also be beneficial to hear from non-students, such as those working with marginalized groups and communities.

Rustica AGM Report
Wednesday 13th October
Report by Tim Starkey

The Rustica AGM was held at 6:30pm on 13th October in CSLT 1 with food and beverages served in Club Med afterwards. The meeting was relatively poorly attended, possibly due to the close proximity of exams. Despite this, the meeting was very successful with some constructive amendments made to the constitution and a new committee elected. The constitutional amendments mainly involved changes to the structure of the committee to encourage greater multi-disciplinary involvement and to allow more efficient operation of the club.

Many of the committee positions were hotly contested, the end result producing a committee with multi-disciplinary representation and having every year level represented. The Rustica Committee for 2005 is:

President:	Wendy Henderson (Med III)
Vice-President:	Alannah Smith (Pharm III)
Treasurer:	Jo Ambrose (Med III)
Secretary:	Ashlie Hill (Med II)
NRHN Snr Rep:	Tim Starkey (Med VI)
ATSI Rep:	Matt Spotswood (Med VI)
RHSV Reps:	Robyn Gunston (Pharm III) and Kaylee Nash (Med II)
Nursing Rep:	Katie Walker (Nursing III)
Pharmacy Rep:	Gemma van der Valde (Pharm III)
NRHN Jnr Rep:	Lenore van der Merwe (Med IV)
Publications/Media:	Zoe Ling (Med II)
International Rep:	Jenny Flynn (Med IV)
Societies Rep:	Shannon Withers (Med III)
Rural Clinical School Rep:	Melanie Wuttke (Med V)
Launceston Rep:	Sarah Donoghue (Med V)

Congratulations to the new committee members and thanks to the outgoing committee for their great work this year. Special mention should be made of the sterling effort that Eddie Vergara has put in as both President and NRHN Snr Rep, managing both admirably.