The Royal Australian College of General Practitioners

National Rural Faculty

# BushAlert

December 2007

## In this issue

Chris' Christmas message 1
The 15th NRF at the 50th ASC! 2
Learnings 4
National Rural Health Action Week 5
Student report 6
Registrar report 7
Competition! What do you hope for in 2008? 7
Northern Territory emergency intervention – share your story 8
WONCA 2008 9
New RACGP curriculum integrates rural general practice 10
Training grants for rural and remote procedural and emergency medicine GPs – are you missing out? 11
Di's desk 11
Certificate in Primary Care Skin Cancer Management 11
Profile of a rural GP 12
Interesting links 12

## Dont miss...

The 15th NRF at the 50th ASC **Page 2**

Student report by Shannon Nott about the rural appreciation weekend at Dunedoo **Page 6**

Northern Territory emergency intervention – real stories from doctors **Page 8**

New joke section – beat around the bush **Page 12**

## Chris' Christmas message

Dr Chris Mitchell
Chair, National Rural Faculty
RACGP Vice President

With the election out of the way, now is the time to focus on the proposals we had for the federal government before the campaign got underway – the ones based on the concerted feedback from the National Rural Faculty's (NRF) 5400 members from around the country who support practical solutions to problems.

One of our submissions is for an equivalent to the Training for Rural and Remote Procedural GPs Program for rural general practitioners (GPs) delivering advanced skills services in nonprocedural areas such as mental health and Aboriginal and Torres Strait Islander health. The faculty has, with our partners in the current program, the Rural Doctors Association of Australia (RDAA) and Australian College of Rural and Remote Medicine (ACRRM), persuaded the government to expand the funding for rural GPs delivering emergency medicine services, and for procedural GPs in RRMA 2. It's now time the government started supporting nonprocedural advanced skill practitioners.

Similarly the proposal, which NRF members responded to last August, for a teaching practice capacity building fund, a doubling of the medical student teaching practice incentive payment, a national mentoring network and sessional SIP, and a SIP for mentoring IMGs, is now before the government with full costings – thanks to your responses.

We can't promise you either of these programs for Christmas, but can promise you faithfully that we will waste no time in getting back into Canberra to remind the government of the issues in rural general practice they need to address.

I hope you all have a restful Christmas period. You have all worked hard and deserve a break with your families.

To close my final Bush Alert message for 2007, I would like to share with you plans that our NRF board members have for Christmas.

As for me, I'll be thinking of you all, of course! See you in the New Year!

*'I am planning a quiet Christmas with my parents in Toowoomba. I wish all NRF members a safe Christmas and a Happy New Year.'* Kathryn Kirkpatrick

*'I plan to be at home as much as possible. All four children will be home. If it's a hot day, we'll go to the beach to cool off. If there are any palliative care patients, they may be visited, as I am not on general call.'* John Kramer

*'I love the Christmas season – celebration, carols, fine food and advent church services. As I don't have family in Alice Springs, I will spend time with some of the Yapa Aboriginal people from my church and other friends. We usually have an 'orphan's' Christmas dinner on Christmas Day, providing a home and shared meal for those of us without family in town. This is what Christmas is all about – celebrating the real reason for the season and sharing fellowship.'* Louise Elliott

*'I am having Christmas on 24 and 25 November. There are 40 members of my family coming along (three generations). We originally started in my small town and are now living all over Australia and the world. We also plan to have a birthday party for all family members who have their birthday in October, November or December – that's eight birthdays. It is hard with a large family to all get together, but by having it early everyone can come, except those from overseas – they are thinking of coming next year. Happy Country Christmas.'* Annette Newson

*'My Christmas plans this year involve catching up with as much family as I can. Unfortunately with Christmas being on a Tuesday, this may be difficult as we are spread all over the state, but all I can do is try my best.'* Naomi Harris ■

# The 15th NRF at the 50th ASC!

**It was great to see those who managed to find the necessary cover to attend our activities at the college's annual scientific convention last month, and join us at our NRF rural forum and annual general meeting. In our own 15th year, it was great to be part of the 50th national college conference.**

L–R: Dr Chris Mitchell, Rick Schaefer winner of the the inaugural 'Friends of the NRF' award, and Dr Naomi Harris

Dr Peter Rischbieth, RDAA President, took members through a detailed case study that demonstrated the real costs involved in taking medical students, postgraduate year doctors and registrars, leaving no doubt about the clarity of the case for further federal investment in teaching practice capacity. Dr Mandy Leveratt, Senior Policy Officer with Rural Health Workforce Australia (formerly ARRWAG), took us through the changes in the emerging workforce of GPs, particularly in terms of a preference for flexible work arrangements and multidisciplinary teams. These provide an equally clear indication of the models of rural general practice that need to emerge in order to capture the interest of the increasing numbers of medical graduates due over the next 5 years.

Professor Sandy Reid, from southwest NSW, brought to the attention of members the frustration experienced by international medical graduates and registrars who have to leave families behind in capital cities in order to undertake rural terms and the impacts on the training practices that follow.

Dr Philip Dawson sent a plea from Tasmania for an IT solution for the new national drug charts, so that rural doctors and their teams can use their databases to simplify and reduce errors in their hospital prescribing.

Dr Clive Auricht, from South Australia, sought to remind members of the value of emergency medicine training for emergency teams in their own team setting. Dr Auricht worked on a proposal for an outreach emergency medicine fly-in workshop program with General Practice Education Australia (GPEA) a couple of years ago, which the NRF will now take up.

Dr Jane Mills, President of the Association of Australian Nurses and Midwives, and Shelagh Lowe, Services to Australian Rural and Remote Allied Health, joined Drs Rischbieth and Mitchell in conducting a workshop on multidisciplinary teamwork, aimed at encouraging rural GPs to look at ways of improving their quality of care and practice sustainability through multidisciplinary solutions. Dr Tim Malloy, Chair of the new Rural Faculty of the RNZCGP, and Karen Thomas, Executive Officer of the RNZCGP, joined our board on Wednesday 3 October to discuss ways in which our two colleges' rural faculties could work together.

So it was a very busy few days, and one which culminated in the ever popular Rural and Registrars Dinner, hosted by Dr Naomi Harris, Chair of the GPRA, and Dr Mitchell.

Dr Rischbieth announced an initiative launched that day by the RDAA in conjunction with the Australian Medical Association, calling on the government to fund a rural isolation allowance for Australian GPs and a procedural and emergency medicine loading.

The dinner, held on the old South Steyne harbour ferry, now permanently in Darling Harbour, also featured our Rural Registrar of the Year award and the NRF Student Bursary. If we are talking about the future of rural general practice, this year's award winners typified all that is good about it.

L–R: Drs John Alam and Ken Wanguhu enjoy the night

L–R: Dr Jane Mills, Dr Tim Malloy and Ms Shelagh Lowe at the South Steyne

Dr Clare Willix, our Rural Registrar of the Year, based in Kalgoorlie, Western Australia (WA) with WAGPET, took the assembled delegates through a touching presentation on her life in remote WA, and the team members she works with, servicing a largely Aboriginal population. Clare is already teaching the next generation.

Alina Harriss is completing her penultimate year as a medical graduate with Flinders University attached to a general practice in Mt Gambier, South Australia, as part of the Parallel Rural Community Curriculum. When it commenced 10 years ago, the PRCC was a pioneer in Australia for what has emerged as the Rural Clinical School movement. The achievement of the PRCC demonstrated conclusively that not only did students who undertook an entire year of their studies in a rural community placement do as well as their city based peers in year end assessment, in many cases they did better.

The following evening, we were joined by Rachel Harvey, based in Glenden, northern Queensland, who was awarded General Practice Registrar of the Year 2007. Rachel is a remote vocational training stream registrar. In solo practice with remote supervision, she is dispensing, updating her practice and providing high quality primary health care for her community. She is also supporting the local mine and completing by distance education a Graduate Diploma of Occupational Health and Safety.

All three professionals illustrate the generational change on the horizon, and their examples are showing a very bright and exciting future for rural general practice. ■

Dr Peter Rischbieth, RDAA President, announces a joint RDAA/AMA rural rescue package

**photos: all images courtesy Yme Tulleners, Kirkland Photography**

The NRF is proud to publish an edited version of the winning essay for this year's Rural Medical Student Bursary, Alina Harriss

## How could my involvement in a rural community contribute to improved outcomes for my patients and for me professionally?

### Alina Harriss

I come from a rural background and am dedicated not only to rural health care, but to rural life. I grew up in a small town on the New South Wales/Victoria border and moved to begin my undergraduate degree. On commencing my current degree in medicine at Flinders University, South Australia, I was privileged enough to be granted a Rural Australian Medical Undergraduate Scholarship (RAMUS). This has provided me with financial support and, importantly, an arrangement where I am involved with a GP mentor in Mildura, near my own home town. In addition, I have been involved with the Flinders University Rural Health Society (FURHS), participating in a number of activities with a rural focus. Currently, I am completing the entirety of my third and penultimate year of medical schooling in the rural town of Mount Gambier (made possible through the Parallel Rural Community Curriculum [PRCC], an optional part of Flinders University's medical program).

My current involvement in rural medicine through the PRCC program has a positive bearing on my own professional outcomes. I believe I now have opportunities which few of my contemporaries have – close access to patients and clinical opportunities which many of my colleagues will not have until later in their career. This gives me privileged learning experiences which, I hope and believe, will make me a better doctor.

Through my involvement with my GP mentor in Mildura, I have become interested in, and part of, health care provision in my home town. Patients often feel they have a special investment in me as a local medical student, and so patients and doctors alike are more than happy with my presence. As a student from a rural background, I find it easy to build a rapport with rural patients. The things we have in common aid in building a therapeutic relationship. This greatly enhances my opportunities for learning and participation.

L–R: Dr Chris Mitchell and Alina Harriss, winner of Student Bursary Prize 2007, at the Rural and Registrars Dinner

I believe that studying or practising medicine in a rural area, where specialties are more inclusive by necessity, gives a broader experience than in urban areas where specialties are narrower and more discrete. This makes for a more interesting career, and for more multiskilled doctors, who can in turn be more useful to patients wherever they practice. If, at times, I must live and work in a large city to study or further my career, the skills and knowledge I have gained rurally will benefit many of my patients; my understanding of health care provision and challenges in rural areas will allow me to provide appropriate, sensitive care for those who have travelled from country areas to visit specialists. I can also be an advocate for rural doctors and patients where they are generally not so visible.

I believe that the most reliable way to bring doctors to rural areas is for people from rural origin, like me, to enter the study of medicine. With this as motivation, I have started to promote this course to students. I have spoken to senior students at my former secondary school, encouraging and informing them of options available to make it easier for rural students studying medicine. As a future doctor, I am keen to teach and supervise juniors. I believe that the most valuable teachers are doctors involved in clinical work who are passionate about their own work, giving students an enjoyable and inspiring experience. Thus I think that as a doctor passionate about my work in rural practice, I can make a valuable investment in the future of rural medicine by inspiring others studying medicine.

# National Rural Health Action Week

The National Rural Faculty joined a host of rural health organisations participating in National Rural Health Action Week (28 October – 2 November), launched by the Rural Doctors Association of Australia on the steps of Parliament House.

During this week, the faculty's particular call was for urgent government investment in training for multidisciplinary primary health care that seals the gaps in the rural recruitment pipeline.

Mortality rates for rural men are 15% higher than for their urban counterparts and 9% higher for rural women. Rural Australians access upward of one-third less in Medicare claims. Yet hospitalisation, especially from falls, cancer and accidents, and risk factors such as alcohol consumption, smoking and socioeconomic disadvantage, all increase with rurality.

Research shows rural health consumers expect access to anaesthetic, obstetric, minor surgical and other minor procedural services without expensive and traumatic separations from their family and friends in distant metropolitan hospitals. They expect their local GPs to be able to deliver these services locally, without unnecessary referral. But where are these GPs? Ten years ago, in Australia's most inaccessible and remote regions, the availability of GPs was less than half that in the city. Although this gap has reduced significantly thanks to well targeted government initiatives, there are still 40% more GPs for city dwellers than for their rural and remote counterparts.

A steady reduction in GP working hours among emerging GPs, along with changes in attitude to practice ownership, mean that we need more than just numbers to plug the shortfall identified in the 1990s. We need to attract more GPs to rural general practice rather than just enough.

The way to achieve this is to offer emerging health professionals (doctors among them) what the current evidence indicates they want: flexible working practices in multidisciplinary health care teams.

Strong rural primary health care based on constructive collaboration between health professionals in a team setting will enable us to tackle the workforce shortages affecting health care provision across rural Australia. It is the only way we will be able to contain rising health care costs at the same time as meeting the care needs of rural communities.

The NRF joined its fellow rural health organisations during National Rural Health Action Week in calling on government for a commitment to a rural health obligation which sets the standards that all rural Australians deserve when it comes to accessing local health care. We need:

- a well trained and skilled generalist medical and primary health care workforce
- recognition and reward for generalist competencies medical, nursing and allied health
- targeted incentives for all health professionals involved
- integrated primary health care infrastructure, and
- effective primary health care teams.

This is a big ask, and it will take a 'big' government to negotiate real investment in a whole-of-system solution with the combined rural health professions. ■


gp psych support

Helping you help your patients

Free patient management advice for GPs from a psychiatrist within 24 hours

To access GP Psych Support:

Tel 1800 200 588

Fax 1800 012 422

Online Log in and submit questions online at www.psychsupport.com.au

Expanded to provide advice from specialists in both child and adolescent, and drug and alcohol psychiatry

GP Psych Support is not intended for emergencies. These patients should be referred to your normal acute psychiatric service.

Funded by the Australian Government as part of the Better Outcomes in Mental Health Care Program

# Inaugural rural appreciation weekend at Dunedoo

Shannon Nott

The Rural Allied Health and Medical Society from the University of New South Wales (UNSW) held a camping rural appreciation weekend on 19–21 October on a sheep, cattle and cropping property 10 km outside of Dunedoo, NSW. The weekend was designed to promote rural lifestyle to participating students, who have mostly grown up in city areas. This was seen as a need by the executive of RAHMS as students, especially those having never resided in rural Australia, often do not fully realise the need for rural health professionals, and are also not aware of the opportunities available 'in the bush'.

Through providing students with an idea of what rural life is like, the rural appreciation weekend allowed students to start thinking about careers in rural areas, attempting to address the shortage of rural doctors in Australia. Participants included medical students from UNSW and allied health students from the University of Wollongong. By having this weekend, students were able to see the importance of multidisciplinary teams in health care as well as giving them opportunities to network.

Students interacted with locals from Dunedoo and the talks given by local GPs proved invaluable, especially for our city dwellers. For one candidate, this was a highlight of the weekend, especially since Dr Tilak Dissenayake made the transition from city to country and spoke about the benefits of working in the bush.

Students toured 'Oakfield', the property where the weekend was held. They learned about the difficulties that farmers face during drought, and that it is the lifestyle that rural Australia offers that keep many farmers on the land despite the adversities.

There were many orientated activities (both rurally and medically) held throughout the weekend. These included: a snake exhibition, highlighting common mistakes doctors make when treating a snake bite and what can commonly go wrong; a sheep dog and shearing exhibition; an Aboriginal cultural awareness session; and a teamwork activity involving drafting and moving sheep. Students also toured Simon Gilbert Vineyards in the Mudgee region.

Feedback from the weekend was incredibly enthusiastic, with many students labelling the weekend as priceless and one of the best opportunities to be involved in for students thinking about working in rural areas.

RAHMS intends to hold the rural appreciation weekend in 2008, and believes that learning opportunities such as this are essential in combating the shortage of health professionals in rural Australia.

## Registrar report

### Naomi Harris

#### Looking back at my exam experience

15 September, 27 October and 3 December. What do these dates all have in common? Stuck? They are all going to go down in history as the worse days of my life. 15 September was the day of the 2007.2 written FRACGP Examination. I was glad when those 7 hours were over! I read a Murtagh book, did *gplearning* and used a number of books from the local hospital library – all in the hope that I would learn the gems to take me over the line.

27 October was the day of the clinical exam. I went to St Vincent's hospital in the 'big smoke' for 4 hours of what I thought was going to be…in fact I didn't know what it was going to be. I had dreams of what I was going to be asked and what I was going to do, but it was quite a pleasant experience (if that can be said about an exam!).

I thought it was interesting in parts and there were definitely stations where you could 'show 'em your stuff'.

And on the last date, 3 December – will be the day of reckoning, the day when all will be revealed and results made available. I am not sure yet whether I want that day to come; but then when I think about it … damn it, I just want to know! I want to know if all the study and the practice questions were worth it. I want to know whether I pick the books up again and knuckle down for more study. I'll keep you all posted on that one. Have a great Christmas! ■

## COMPETITION!

### What do you hope for in 2008?

**Do you have any exciting plans, visions or 'must dos' for 2008?**

Share with us your plans for 2008 and you could win a Christmas hamper! The most interesting response will win and a selection of responses will be published in the February issue of *Bush Alert*. Stories should be 1–2 paragraphs. Email your story to emily.fox@racgp.org.au by Monday 17 December. The winner will receive the hamper in time to celebrate Christmas.

- Save your practice money
- Streamline and track your ordering
- Shop online for general practice supplies
- Access an ever expanding range of products
- Receive regular special offers
- Order from multiple suppliers

**GPDirect™** offers RACGP members* access to a huge range of products at competitive prices.

**GPDirect™** offers your practice competitive prices based on the bulk buying power from practices all around Australia. **GPDirect™** negotiates with suppliers for your practice's advantage.

**GPDirect™** makes ordering supplies simple with its up to date online catalogues therefore saving your practice time. Products range from height adjustable beds to vaccines to medical and practice consumables.

**GPDirect™** is available exclusively to RACGP members via the *MyGeneralPractice* e-portal.

* A separate monthly subscription fee applies for access to this service and it is only available to RACGP full financial members.

**www.racgp.org.au/gpdirect**
**1800 677 638 ~ helpdesk@gpdirect.net.au**

# Northern Territory emergency intervention – share your story

Back in October NRF members will recall we sought your stories on the federal government's NT emergency intervention. The faculty board became aware that there were different experiences among those already delivering GP services to Aboriginal and Torres Strait Islander communities in NT and those flying in and out as part of the federal government intervention – and not necessarily any communication between the two.

The board invited contributions from members in the hope that sharing stories may lead to improvement for all involved. In this issue of Bush Alert we have published two contrasting experiences. We encourage members to send in their experiences, which will be published on the NRF website at www.racgp.org.au/rural. Click on the link 'Federal government Northern Territory intervention – share your story' on the left of the page.

Titjikala – one of the communities targeted by the intervention

## Dr Louise Elliott

### Alice Springs, Northern Territory

I'm currently a GP (rural medical practitioner, previously known as district medical officer) working with Central Australia Remote Health, and have been for the past 3 years. I write this reflection as the NRF NT representative. I currently work with a team of doctors based in Alice Springs, who regularly visit NT government run health centres in remote indigenous communities. My main 'patch' is Titjikala and Aputula (two of the first communities targeted by the intervention).

The NT intervention came as a surprise to us. We weren't sure what our response should be. As time progressed it became clear that the team of GPs I work with would have minimal input into the intervention's child health checks. We initially offered to do the health checks if any visiting doctors could help us in our routine work, however, this offer was initially refused by the NT government (and to my knowledge, the federal government as well).

Months later, the intervention doctors have come and gone from our communities in central Australia. Many have not bothered or been encouraged to make contact with the regular visiting rural medical practitioner. The orientation for these visiting doctors has been such that they are surprised to find out that there is a team of committed GPs already attending to the needs of the communities. I was fortunate to have had contact with the doctors that visited my patch, and found the dialogue that ensured invaluable. I have been able to acquire an unofficial list of referrals made/follow up required for my communities. There has been no formal way of reporting back the findings of the health checks to the regular visiting doctor.

As GPs, we feel that we have been left in the dark. There is a paediatric liaison nurse (finally employed by the initiative) who has been receiving and tracking these referrals, but we are not officially privy to them. Health centres that are well run have been able to maintain reasonable tracking of the referrals. There has been no acknowledgment or recognition from the intervention that the team of GPs who are presently working in central Australia are already doing a much needed service and are simply under-resourced.

The health checks have duplicated the HSAK screen (healthy school aged kids), and GAA (growth assessment and action) programs that are already in place and functioning well. These checks are already being done yearly in most communities. Unfortunately, despite the comprehensive health checks completed, the federal initiative teams have not found anything that we did not already know. The regular community paediatricians have received referrals for children they already knew about and dealt with. These paediatricians work closely with our team, and are also not informed about the findings from the health checks.

In terms of the impact of this on our communities, I have had to do a lot of 'damage control', reassuring everyone that the army is not coming to take away their children, is not going to do invasive sexual checks, and that I am still their regular doctor and can still see children. This loss of rapport with these communities is heartbreaking after building strong and trusting relationships with them, particularly with the women. In indigenous communities, a sense of engagement with people is more important than filling up the dosette box with pills. For me this has been undermined. It took me at least 12 months of regularly visiting a community to reach a stage of reasonable engagement with the people, where they felt able to trust me.

While the increased awareness of the plight of indigenous people living in poverty is welcome, those of us living and working here are keen to focus on what is working well with the system. This is the start of encouraging and affirming Aboriginal people to be strong in their cultural values and not simply become survivors at the expense of a dominant white fella culture, but rather thrive in crossing the two vastly different cultures.

As medical professionals, we need affirmation and recognition that we are already doing a job in difficult and trying circumstances, and endorsement to continue. We need resources and, more importantly, GPs who are willing to commit for the long haul (not just 2 weeks), as we continue trying to build up remote Aboriginal communities, and help strengthen them to keep the 'little children sacred'.

### Dr Carol Cox
**Toowoomba, Queensland**

I was involved in the NT indigenous health intervention in the second half of July. We were given rapid orientation in Alice Springs which was extremely helpful, especially the outline of the Tchicurrpa system of indigenous beliefs and the session on remote area clinical practice organised by NT Remote Area Nurses.

The CARPA manual was invaluable, and after our deployment we were all asked to contact the 'Bush Crisis Line' whether we had problems or not, and let them know how we were going.

The debriefing was conducted in 'craft groups' at my suggestion, with a strengths/weaknesses/opportunities/threats format which was helpful, but in such a short time frame, briefing and debriefing cannot take up too much time or we'll have no time in the communities.

As far as I know, most of the GPs who went out on my deployment made personal telephone contact with the GPs providing regular services in these communities. Although they had been left out of the loop initially, I think there was good rapport by the end of our stay, with some personal networking too.

The emergency response was initially in a continual state of change while teething troubles were addressed, eg. wrong supplies for the teams, cumbersome forms and the difficulties of 'throwing teams together' and expecting them to gel instantly, and get an unfamiliar job done.

However, I firmly believe that innovative programs have to cope with those rigours and the challenge now is to keep the momentum going for positive outcomes in the long term.

The spin offs of this program are often more valuable than the main menu which is something that we all learned very quickly on the ground.

I would strongly recommend my colleagues to lend a hand – it is Médecins Sans Frontières without the war!

# WONCA 2008

General practitioners and all those interested in the practice of family medicine are invited to Melbourne, Australia for the WONCA 2008 Asia Pacific Regional Conference, which is combined with the RACGP 51st Annual Scientific Convention 1–5 October 2008.

Our conference theme, '*A celebration of diversity*' explores the wide ranging, all encompassing nature of our profession in providing primary care to our patients, communities and nations, in the multicultural city of Melbourne.

WONCA is an unusual yet convenient acronym comprising the first five initials of the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. WONCA's short name is World Organisation of Family Doctors.

WONCA is made up of 65 national colleges, academies or organisations concerned with the academic aspects of general family practice from 56 countries. The total world membership of WONCA is over 150 000 GPs/family physicians.

Come and participate in a high quality professional program in first class conference facilities and enjoy the world class attractions of our city. Cosmopolitan Melbourne offers a unique international mix, reflected in the diversity of food, cultures, languages and lifestyles and promises an unforgettable conference experience.

## Key dates

**January 2008 Abstract submissions open**

**April 2008 Abstract submissions closes**

**July 2008 Early bird registration closes.**

**For more information visit www.wonca2008.com.**

# New RACGP curriculum integrates rural general practice

One of the least highlighted features of the new RACGP Curriculum for Australian General Practice is how rural general practice issues have now been integrated into all parts of the general practice learning lifecycle.

From the beginning of next year, all new medical students will have the new general practice curriculum to guide their career path from the first step until vocational training and beyond, and for this reason, rural issues now play a fundamental role in all stages of training.

The RACGP curriculum sets the standards for the knowledge, skills and attitudes necessary for a competent, unsupervised GP to care for patients and to support the current and future goals of the Australian health care system.

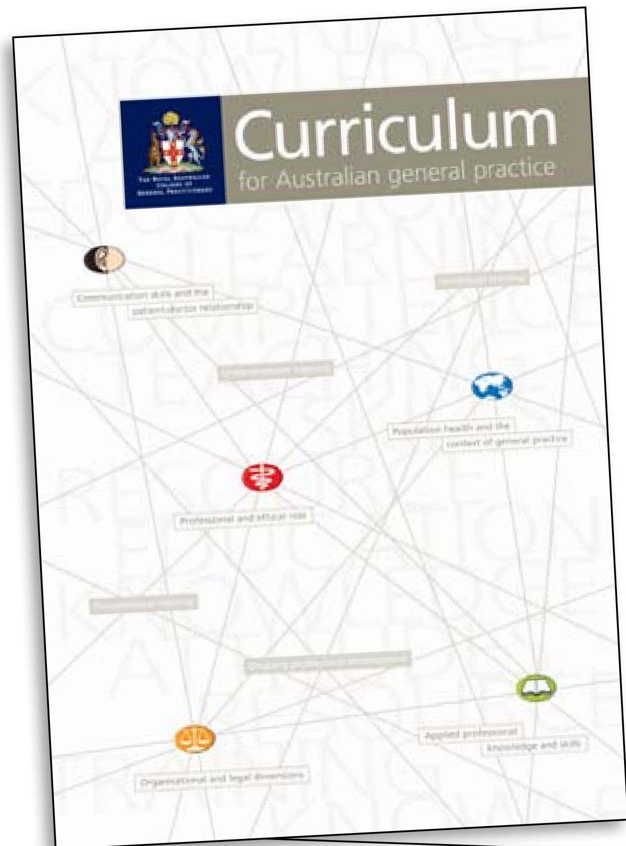
While the majority of GPs work in urban areas, knowledge of the special needs of people living in rural areas is critical to patient management, especially in areas such as patient referral. In addition, almost all undergraduates, prevocational doctors and general practice registrars, will work at some stage in rural and remote areas, and the new curriculum provides a welcomed opportunity to consolidate their practical training into a coherent body of knowledge.

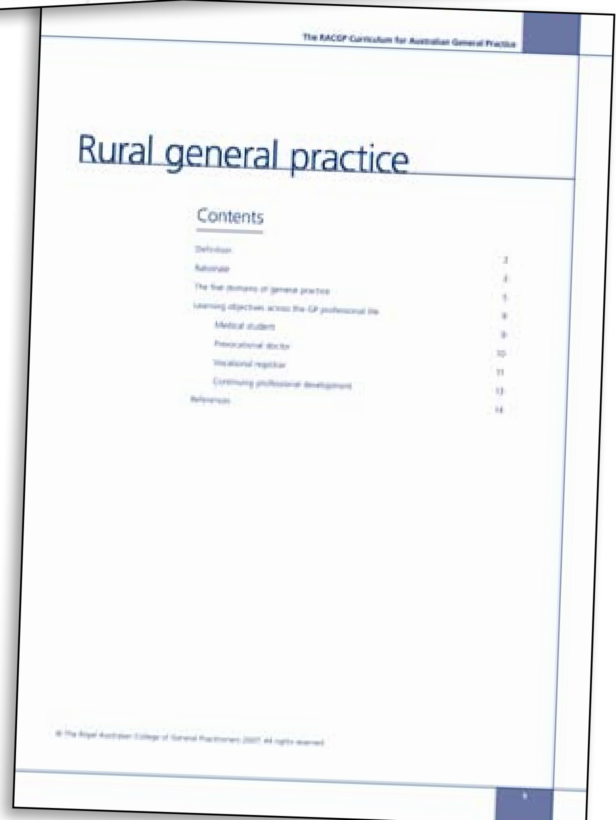
The revised curriculum has been adapted to the evolving general practice training environment, as well as national health priorities and emerging patterns of health reflected in the increased number of statement areas.

Each curriculum statement has been revised by the NRF to ensure that rural issues are highlighted throughout every area of interest. The curriculum has been circulated to a wide range of stakeholders, who have also provided valuable suggestions for improvement which have been incorporated.

In addition, under the section of *People and populations*, the statement *Rural general practice* provides a concise overview of the rural educational needs of GPs in a way that is easy to integrate into any stage of training. Written and developed by the NRF, the statement can be downloaded from the college website.

The RACGP Curriculum Committee would like to pass on their special thanks to Richard Lawrance and Di Schaefer who have provided unstinting expert support throughout the writing and consultation process. Their work has made a huge difference to the overall curriculum, in ensuring that it has remained at all times and levels relevant to Australian rural general practice. ■





The RACGP Curriculum for Australian General Practice

Rural general practice

Contents

**The RACGP curriculum is available online at www.racgp.org.au/curriculum.**

# Training grants for rural and remote procedural and emergency medicine GPs – are you missing out?

The Training for Rural and Remote Procedural GPs Program is now into its fourth year of operation and continues to gain momentum as increasingly more doctors 'in the bush' access grants to maintain their skills in obstetrics, anaesthetics, surgery and emergency medicine.

Since the program commenced in July 2004, 1266 rural and remote doctors have registered in the program through the RACGP. The majority of registrants are GPs living and working in country areas, however, 98 are doctors who are based in urban and regional centres and undertake country locums.

If you are a rural or remote proceduralist (providing obstetric, anaesthetic or surgical services in hospitals in RRMA 2–7 locations), you may be able to receive grants to maintain your procedural skills. Applicants from RRMA 2 locations must meet strict eligibility criteria. Doctors working in 24 hour triaging facilities in RRMA 3–7 locations may also qualify for training grants to maintain their emergency medicine skills.

For further information, please contact Pauline Curtis on 1800 636 764 or 08 8267 8351, or email pauline.curtis@racgp.org.au or visit www.racgp.org.au/rural/traininggrants. ■

## Certificate in Primary Care Skin Cancer Management

The RACGP, together with the Australasian College of Dermatologists, is pleased to announce the upcoming release of the Certificate in Primary Care Skin Cancer Management course.

This course consists of four online modules, a 2 day workshop and a clinical attachment of 12 sessions. Completion of this course will be a prerequisite to complete the Certificate in Primary Care Dermatology – to be offered by the end of 2008.

The online modules are a prerequisite for attendance at the workshop and the clinical attachment. The dates for the 2 day workshop have been set for 8–9 March 2008 in Sydney. Further workshops in other areas are being planned.

Expressions of interest can be emailed to dermcert@racgp.org.au. Enrolments will commence by late November. More information, including fees and course curricula, will be sent via email to those registering interest.

## Di's desk

Well, it's that time of the year again – Father Christmas has officially arrived in Adelaide, joining the Christmas pageant. The city of Adelaide is abuzz with approximately 350 000 people watching the wonderful parade from behind the famous 'blue line'.

The online development of the Fellowship in Advanced Rural General Practice is progressing steadily. Our goal is to have the entire program accessible through *gplearning* by the end of 2008. There are 195 current enrolments in the FARGP/Grad Dip Rural – 168 registrars and 27 practising GPs, and I'm confident that we'll meet our target of 200 enrolments by the end of 2007.

I continue to visit regional training providers, and work with state faculties to provide quality educational activities for our rural members. I have also presented sessions regarding the college's products and services at AGPAL workshops and on the new QA&CPD triennium, so life continues at a hectic pace!

I welcome Leticia Shields, our new Education Administration Officer. Leticia started in the Adelaide office 4 weeks ago and is rapidly 'getting her head around' her job.

We have also appointed Bryan Foley, Rural Education Officer, who will start in early December. His role is to assist me and take on roles that I don't have the time to undertake.

Please remember, if you have any questions about the FARGP, please don't hesitate to contact me.

I wish you a joyous festive season, and a happy and safe new year.

**Di Schaefer**
***National Rural Senior Education Officer***

## Profile of a rural GP

# Dr Louise Elliott

I am a GP currently working with Central Australia Remote Health, based in Alice Springs. I graduated from the University of Tasmania in 1999, and commenced my GP training in Latrobe, Tasmania, and then Scottsdale in rural Tasmania. In 2003 I moved to the Northern Territory to complete my rural GP training in Katherine, Darwin (completing a DipRANZCOG), and finally Alice Springs.

It was Alice Springs that captured me the most, so I stayed to do an advance rural skills post in Aboriginal health to finish my Graduate Diploma of Rural General Practice. Like so many people who come to Alice Springs, I have stayed well beyond my initial 6 month term.

My current role as a rural medical practitioner allows me to be based in Alice Springs and to travel out to remote Aboriginal communities in central Australia on a regular basis. I am also part of a team that maintains an on call telephone service to the region and arranges the aeromedical retrievals with the Royal Flying Doctor Services.

### What attracted you to rural general practice?

I had a fantastic rural term as a medical student. I could see that I would really enjoy the diversity of practice, and the freedom to get to know patients on a down-to-earth level. I never liked the 'big smoke' anyway, and any more than 7 minutes driving through traffic would frustrate me!

### What is one thing you've learnt?

I don't do broken sleep very well! No seriously, I have learnt that in order to be able to look after others with any integrity, I need to look after myself.

L–R: Aboriginal skin sisters, Bertha Nakamarra Dickson and Dr Louise Elliott

### Why is Alice Springs a great place to live?

I only have to travel 5 minutes to get to work. There are only eight sets of traffic lights, and so many great places close enough to town that it doesn't take long to jump in the car and be out of town to get away from it all. Besides, when King's Canyon is your office, where else would you want to live? Alice Springs is a cultural melting pot, with many people from all over Australia as well as the world visiting, living and working here. There are numerous festivals, performances and cultural events happening all year around. The weather really isn't that bad most of the year – clear blue sky 90% of the time! There is a saying here, that if you have seen the Todd River flow three times, then you are a local! I guess I'm here to stay for a while.

## Interesting links

**www.blackwellpublishing.com/aims.asp?ref=1038-5282&site=1**

The Australian Journal of Rural Health for articles in the field of rural health.

**www.racgp.org.au/library**

The RACGP John Murtagh Library has a unique and specialist collection of general practice related resources, and a team of experienced, helpful staff.

**www.nrhn.org/**

The NRHN is a multidisciplinary network representing medical, nursing and allied health students aiming to increase the health workforce and health outcomes for rural and remote Australians.

## Beat around the bush

### Disclaimer and contribution guidelines

Contributions to Bush Alert are welcome and can sent via email to rural@racgp.org.au or fax to 03 8699 0598 or by mail to: National Rural Faculty, 1 Palmerston Crescent, South Melbourne, Victoria 3205.

Please note the following maximum word limits are: articles: 250 words; classifieds 200 words; feature articles:500 words.

If you wish to check the deadline, please call Emily Fox on 03 8699 0421.

Disclaimer: While every effort has been made to ensure accuracy, the publishers, authors and editors are not responsible for the results of any actions on the basis of information in this work, nor for any errors or omissions. The opinions expressed are not necessarily those of the publisher.

© The Royal Australian College of General Practitioners. All rights reserved