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### PROJECT REPORT

# ‘Even if we get one back here, it’s worth it...’: evaluation of an Australian Remote Area Health Placement Program

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### A B S T R A C T

**Introduction:** In 2006 the Kimberley Remote Area Health Placement Program (hereinafter the ‘Program’) was established at the University of Notre Dame’s School of Medicine (Fremantle campus, Western Australia). The Program was developed as one of the strategies to achieve the School of Medicine’s mission to graduate knowledgeable, skilful, dutiful and ethical doctors who will want to work in Australian areas of unmet need. The Program aims to immerse medical students in non-clinical settings to provide them with opportunities to learn life skills required for remote area living, and to introduce them to the myriad of socio-cultural, geographic, climatic and economic factors that impact on the health and wellbeing of remote area residents. To meet these objectives, the School organizes for students to live with, and do useful non-clinical work for, a host community or organization for up to one week. In 2008 the Program was evaluated to explore and assess its immediate and potential future benefits and limitations as perceived by Kimberley residents. This paper reports on the evaluation’s findings via Kimberley-based narratives and raises some issues that are essential to training and retaining a ‘bloody good doctor...’ in a remote Australian setting.

**Methods:** Using a mix of qualitative, ethnographic methods, the Program was evaluated by an independent researcher during four weeks of field research in late 2008. The methods included a survey, structured and unstructured interviewing and participant



observation to elicit data. Thirty-three formal interviews of at least one hour's duration were conducted. Data were also collected via 15 informal discussions. Both formal and conversational interactions occurred in a range of town-based and more remote settings.

**Results:** The majority of persons consulted generally highlighted the Program's benefits. The reasons for this positive evaluation varied, but a common thread was that exposure to the Kimberley introduced the students to local life, a quality that had the potential to result in a medical student returning as a qualified doctor. The Program was seen as beneficial because it provided a structured, constructive means for prospective doctors to appreciate the assets rather than the deficits of remote area living. Another positive implication was that the Program equipped future doctors (regardless of their eventual work location) to treat a person from the 'bush'. It also encouraged students to think and act cross-culturally. An important immediate benefit was that the Program offered human resource support to the host organization at a busy time of the year. In only three of the 33 formal interviews was a negative or ambivalent attitude toward the Program expressed. However, a common concern was the brevity of time students served with their host organization.

**Conclusions:** The data collected revealed that Kimberley people believed that the Program held strong potential for the successful recruitment of doctors prepared to make a long-term commitment to the region. Never far from their minds, conversations and activities was the idea that the effort they put into accommodating, supporting and guiding the students was worth it because 'If only one good doctor comes from the Program, then that's a good thing. A good doctor would have a great impact – the implications are immeasurable...'.  

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**Key words:** cultural immersion, medical student, medical workforce shortage, remote area health, rural health.

## Introduction

In 2006 the Kimberley Remote Area Health Placement Program (the 'Program') was established at the University of Notre Dame's School of Medicine (Fremantle campus, Western Australia). The Program was developed as one of the strategies to achieve the School of Medicine's (SoM) mission to graduate knowledgeable, skilful, dutiful and ethical doctors who will want to work in Australian areas of unmet need. Strategies previously implemented to recruit and retain doctors to rural and remote Australia had not been entirely successful, as shown by the fact that a large proportion of medical positions in these areas were either vacant or filled by overseas trained doctors unable to obtain full medical registration to work outside declared 'areas of unmet need'<sup>1-9</sup>.

The Program was also one of the SoM's responses to the consistently poor health status of remote area populations, and especially of Aboriginal groups in northern Australia,

when compared with members of the broader society<sup>10-20</sup>. In this paper, the term 'Aboriginal' is used in preference to 'Aboriginal and Torres Strait Islander' to recognize that Aboriginal people are the original inhabitants of Western Australia.

Based on data collected through the process of evaluation, this article highlights local perceptions of the Program, people's aspirations for improved health services, and their hopes that the Program will result in at least one 'good doctor' returning to live and work effectively in the region for a protracted period of time. Highlighting local 'voices' and drawing heavily on the use of extracts from interviews conducted with people from a cross-section of socio-cultural backgrounds and locations, this paper begins with a brief outline of the 2008 Program and a discussion about methods, and then turns to the evaluation. We conclude by emphasizing the Program's positive implications, local suggestions for change, and recent Program modifications.



## *The Program*

A central question for curriculum developers when developing ideas for a remote area placement program was 'What can we do to make our graduates *want* to work in rural and remote Australia after they graduate?'. The published literature indicated that a rural background (defined as primary and/or secondary schooling) of the doctor and his/her spouse was the most important factor<sup>21</sup>. However, exposure to rural and remote clinical placements, although not fully evaluated, appeared likely to be effective in positively influencing students' perceptions of rural and remote practice<sup>22</sup>. In addition, students needed to be able to conceptualize themselves in a particular role<sup>23</sup> and/or experience what it was like to live in a rural setting<sup>24</sup> when making decisions about where and in what speciality they intended to practice.

Mak's experience (based on 11 years of medical practice in the Kimberley) that most doctors who work effectively and are willing to stay out bush also *loved living* there, provides an explanation for the findings evident in the above publications. Viewed in this light, 'rural background' can be understood not just as an attribute that can only be influenced through the medical student selection process, but knowledge and skills in remote area living that can be learned as part of the medical curriculum. It then became clear that remote area residents are important people to provide the relevant experiences required for students to learn these skills. The relevant factor is that this learning has to be done in lay (as opposed to clinical) settings in which the bush resident is the 'expert' and the medical student is the 'learner', because for any health program to be effective it must ensure that 'the real power ...[is]... placed in the hands of the community'<sup>25</sup>.

With these findings, and Mak's productive and positive experience in a remote area<sup>14,26,27</sup> in mind, the SoM developed a program that aims to immerse medical students in non-clinical settings to provide them with opportunities to learn the life skills required for remote area living, and to introduce them to the myriad of socio-cultural, geographic,

climatic and economic factors that impact on the health and wellbeing of remote area residents. To meet these objectives, the School organized for pairs of students to live with, and do useful non-clinical work for, a host community or organization for up to one working week. (In 2003 Mak and the SoM's Deputy Dean met with West Kimberley Shires and residents at local government and public meetings to ask if they would host pairs of medical students in their workplaces and homes for one week each year. The aim was that the hosts would help to teach the students the joys and challenges of living 'out bush'. The response was overwhelmingly positive. The fact that Mak had worked as a doctor in the Kimberley was a crucial factor in being able to obtain community support. That she was no longer working as a doctor in the Kimberley was equally crucial in ensuring that the SoM and the community were equal partners.) Placement hosts include pastoral stations, schools, Aboriginal communities, aged-care facility and child-care centres, and small businesses. In addition, students meet local medical, nursing and allied health practitioners, and participate in a tour of a healthcare facility.

At the time of writing, about 50 placements are organized each year. These are within or around the towns of Derby and Fitzroy Crossing, although some hosts are up to 200 kilometres from either town, necessitating trips of two to four hours in four-wheel drive vehicles, or charter flights in light aircraft. Placement hosts provide accommodation, often having students in their own homes. Some students sleep on mattresses or in swags or pods in a host organization's office or station bunkhouse ('swag' is a colloquial term for a bedroll; some are slightly raised off the ground and covered, hence the name 'pod'). Many hosts also provide food, local guidance and tutelage, and, where possible, transport to visit locations other than the workplace. Hosts receive a letter of thanks from the SoM's Dean at the completion of each placement in recognition of their unpaid, but invaluable contribution towards medical student education.

Before arriving in the Kimberley, students undergo extensive and compulsory preparatory studies including historical, cultural and linguistic orientation, and debates on topical



issues relevant to rural and Aboriginal health. After they return home, students are required to reflect on their experiences in tutorials and write about them in their professional portfolio for assessment.

Students undertake the Program in the second year of a four-year graduate entry medical degree. This allows them to build on their learning from a four-day rural health program in the Wheatbelt region of Western Australia undertaken in the first year of the course. Both the Wheatbelt and Kimberley programs occur before students undertake rural/remote clinical placements in third and fourth years, so that students have had the opportunity to obtain or improve their rural/remote living skills before being expected to work clinically in these settings. It should be noted, however, that each placement brings with it different experiences and issues; for instance, the Wheatbelt is about 200 km from Fremantle, the Kimberley is over 2000 km away.

## Methods

In late 2008, after three cohorts of students had participated in the Program, an evaluation was undertaken from a social science perspective and in accordance with the University's guidelines<sup>28-30</sup>. The primary objective was to explore and assess the Program's immediate and potential future benefits and limitations as perceived by Kimberley residents. Additionally, the evaluation aimed to assess whether local communities and agencies believed the Program was worth continuing, and to record changes that might help to improve it.

Toussaint, an anthropologist with more than 25 years' research experience in the Kimberley, was appointed to undertake the evaluation in September-October 2008. Drawing on extensive knowledge of the region and its people, she used a mix of qualitative, ethnographic methods during four weeks of field research. Toussaint contacted Kimberley hosts prior to embarking on the research, as well as at its conclusion. The methods included a survey, structured and unstructured interviewing, and participant

observation to elicit data. She also canvassed relevant literature (published works and unpublished reports) and media items. Toussaint conducted 33 formal interviews of at least one hour's duration with 19 women and 14 men. Of this group, six were Aboriginal, and 11 were non-Aboriginal people who worked for local Aboriginal organizations and/or communities. Data collected via 15 informal discussions about the Program also contributed to evaluation findings. This group consisted of 10 women and five men, most of whom were Aboriginal. Both formal and conversational interactions occurred in a range of town-based and more remote settings, including Aboriginal communities, pastoral stations, an art centre, an adult education centre, an aged-care facility, schools, shops, government offices, a river bank, a local radio station, a sports centre and a jetty. The conversations were recorded, transcribed and integrated into a report for the SoM<sup>30</sup>.

## Results

### *Benefits*

The majority of persons consulted about the Program generally highlighted its benefits. A large number of people (30 of the 33 persons formally interviewed, and the 15 people with whom informal, conversational interactions occurred) opened the discussion by exclaiming, 'The Program? 'It's a great idea!'. The reasons for this positive evaluation varied, but a common thread was that exposure to the Kimberley introduced the students to local life, a quality that had the potential to result in a medical student returning as a qualified doctor. This claim is eloquently conveyed through the enthusiastic comments of three independent interviewees:

*The Program? It's a great idea! ...It is a good way to further understandings about health, and in some ways it's a return to a more 'hands on' approach to health teaching. ...It gives potential doctors practical experience, which is what's needed. ...It's also about seasonal time and differences across the Kimberley*



*... and you never know, one of them might come back here... (Interview Data, Education Facility).*

*I think it's a great Program, yeah, the idea of bringing them [students] to the Kimberley so they can learn first hand what it's like here...you can argue until you're blue in the face with some people, like politicians and bureaucrats, about the conditions here but they just don't get it, don't know what it's like, they have to live here really to understand it (Interview Data, Aboriginal Pastoral Program and Government Agency).*

*I think it's a very good idea...the students need to sit with the [Kimberley] experience ... they need less of lectures and more experience in order to even think about becoming good doctors in a remote community. (Interview Data, Government Agency).*

Another emergent theme was the hopefulness people revealed about their aspirations for the Program, namely that it would result in at least one student returning as a fully qualified doctor who would make a long-term commitment to the region and its people. On that basis, hosts were prepared to put a great deal of time and effort into the Program despite having many other demands on their time. These included attending to a complex of socio-economic issues that were regularly associated with poor living conditions (eg sickness, inadequate housing, hygiene neglect), and the perennial problem of trying to work with limited financial resources and without a regular and reliable workforce. The following extracts from interviews make plain people's hopes for the Program, including the view that a new doctor would, by necessity, have to be someone who came to value the region and the life it offered:

*If only one good doctor comes from the Program, then that's a good thing. A good doctor would have a great impact – the implications are immeasurable. You think about it, a good doctor who works here is*

*not only going to treat individuals but that individual is part of a family and so a good doctor affects whole families not just individual people... (Interview Data, Aboriginal Pastoral Program and Government Agency).*

*You know that if he [referring to a medical student] likes the bush he's going to be a bloody good doctor! If he gets out and about, fishing, barbecues, talking with people, then he'll know about how we live, be happy to make contacts, do follow up, you know the sort of thing, he'll get a feel for the place, feel the atmosphere, get into the play area of life outside the hospital... (Interview Data, Aboriginal Enterprise).*

(In the Kimberley Kriol language, the word 'he' encompasses both men and women. In this case, the interviewee referred positively to women doctors, although continuing to talk generally by using the generic 'he'.)

A number of people also observed that involvement in the Program would help the students to see (and hopefully, value) the assets rather than the deficits of remote area living. In this regard, the Program was seen as beneficial because it provided a structured, constructive means for prospective doctors (in the guise of welcome volunteer workers) to appreciate the Kimberley for its landscape, way of life and community spirit. As the majority of interviewees put it, the Kimberley had to be understood in its own terms, rather than in comparison to 'city life'. The following quote is apposite here:

*We don't have a Coles round every corner, but we do have beautiful gorges, fishing for barramundi, and a community spirit. Now what could be better than that? And the wet season, you can't beat it, the wildlife, the new bush, the smells when you drive through creeks, we need to sell these things to doctors... (Interview Data, Aboriginal Community).*





The Program's unforeseen benefits were recognized by at least one participant. For example, one interviewee stated that, alongside the positive implications the Program had for remote areas was the likelihood that medical students (regardless of their eventual work location) would at some time need to treat a 'bush' person:

*Even if only one doctor comes from it, then the Program is a good thing...and if they [the students] don't return to the bush and want to stay to work in Perth then that's alright too, that's what they'll have to do, but at least they'll have an understanding of life in a remote area, and so when a patient from here goes there then they should be a better doctor, they should be in a good position to treat a bush person.*(Interview Data, Pastoral Station).

Another quality was that the Program encouraged students to think and act cross-culturally, resulting in them learning 'not to be scared' of Aboriginal women, men and children, a feeling that several students admitted to their hosts prior to actually meeting and talking with Aboriginal individuals and families. (The complex problem of racism and how and why individuals conceptualize, interact and manage qualitative difference is a huge topic of inquiry and not within the scope of this article to address fully. The problems of 'difference' and health in the Kimberley have been explored in Toussaint's previous publications<sup>14,2</sup>.)

In this regard, it was clear from interviewee comments and activities that they strongly believed cross-cultural experience could help the students to learn more directly about social life, gender relations, local customs, beliefs and behaviours, as well as about the poor material conditions in which many people lived, in an accessible, informative way. Referring mostly to Aboriginal life, but also to non-Aboriginal groups too, the following extracts reveal both the qualities and the complexities of learning about remote circumstances:

*I think the Program was good because [the students] are introduced to holistic perspectives of health ...*

*they see things the way they are, outside the hospital and in the town and communities. ...One of the other benefits was that the students had to work cross-culturally, you just can't work effectively here unless you're looking at the cultural side of things.* (Interview Data, Health Care Facility).

*There are some cultural issues that the students would need to get used to here, to do with women and men mainly. It can be an isolated place and the culture is quite blokey, there's a blokey sort of attitude to most things – it's a bloke's country.* (Interview Data, Pastoral Station)

*The students who were with us were both in their mid 30s, male and female, which was good as there's gender differences in the culture here. They needed to be aware of that too. It's the cultural side of things.* (Interview Data, Aged Care Facility).

Referring more specifically to the marked differences between Aboriginal and non-Aboriginal values, especially with regard to material culture, this interviewee went on to provide the following explicit example.

*Everything we do is cultural, two way... You know there was recently a transition here [from one administrative service body to another]. Someone said to me that we needed to record things like people's watches and jewellery that belonged to the patients and I said, 'what about hair?' You know the sort of thing, how the old [Aboriginal] people keep the hair of deceased loved ones, and this person said to me 'Hair? Hair? No I'm talking about things of intrinsic value'. She didn't realize that hair and not watches or jewellery are of intrinsic value to Aboriginal people. People new to the Kimberley, like the medical students, have to learn about what's of intrinsic value to Aboriginal people... (Interview, Numbala Nunga Nursing Home).*



Other benefits that were described as important but were less consistently put, included the view that having the students around encouraged certain hosts to reflect on their own work practices. One interviewee explained it this way:

*I took [name deleted] on a road trip with me...We had hours of talking in the car and I think this was good talking time. It made me reflect on my practice too, which was an unexpected outcome of their visit...going into local communities I realized how I'd come to normalize certain conditions and behaviours. She was really upset with things like scabies, overcrowding, the poor sanitary conditions and the poverty. I realized that I'd stopped seeing these things so the experience [of the medical student being present] helped me to reflect on my own behaviour, and how I should always aim for best practice...It was a good reminder... (Interview Data, Government Agency).*

That the Program had practical implications was also highlighted as an important immediate benefit, a finding that can be understood in two interrelated ways: that human resources were limited in most of the host organizations interviewed, and that the Program offered support (often described as an 'extra pair of arms and legs') when it was needed. The following extracts explain:

*I think it's best to have students involved in practical work, having them here meant that we had an extra pair of arms and legs which in our area is pretty under-resourced...that worked for them too, I think, because they [the students] needed to see they could provide a service in some way (Interview Data, Government Agency).*

*We hosted two students here, I didn't have a lot to do with them myself but thought that the Program was valuable, has a lot of potential, in part because the students provided us with an extra pair of arms and legs at a busy time...but then we're always busy... (Interview Data, District High School).*

From the selection of data presented, it is plain that Kimberley hosts supported the Program because it was a 'good idea' and held potential for at least one 'good doctor' to return to the area. Others found that the Program encouraged them to reflect on their own practice, and that it served as a cross-cultural vehicle that had positive implications. These qualities notwithstanding, it was also the case that some persons interviewed were concerned to identify the Program's limitations, as well as offer suggestions for improvement.

## **Limitations**

When interviewees were asked to comment on any limitations they associated with the Program, they were also prompted to explore ways to address the problem so that it might be improved, a point we discuss below. In only three of the 33 formal interviews was a negative or ambivalent attitude toward the Program expressed, seemingly derived from working in an already stressed environment where there was little time to devote to the Program. These interviewees, plus several people with whom less formal interactions occurred, were also unclear about Program outcomes and how these might benefit Kimberley people's health.

A common concern was the brevity of time students served with their host organization. As one person baldly put it, less than one working week was 'too quick!'. Although there were a few exceptions to the need to have more time in the region – with two interviewees commenting 'four or five days is enough for the hosts!', and another stressing that they found the time they needed to spend with the students added an extra burden to an already demanding workload – most persons consulted argued strongly in favour of the Program being extended to at least seven days. In each case, people's concerns were explained as giving students sufficient time to become involved in both work and recreational activities throughout the week as well as at the weekend. (Only one person believed that students should stay for two weeks. In his view, they needed to see the Kimberley over 'a two-week cycle, pension week and slack week', to gain an insight into



the dynamics and pressures of local life.) A selection of quotes from interviews and survey data present detail to illuminate people's concerns:

*Overall I think it's a good Program [but] ... I think they [the students] needed more social time [here] to meet with the locals and see what the town has to offer. That way, we might get them back as doctors, if they like the place and the community... (Interview Data, Retail Agency).*

*We had those students [out at the community], but they weren't here long enough - it was too quick! Nobody knew who they were and then they were gone...I reckon they should spend more time, get to know the people properly, it was too quick... (Interview Data, Aboriginal Community).*

*Three or four days here is just not enough, we're happy to host again as it's good for [agency named] to be involved and we're happy to be seen as being involved in such a program, but ... they need more time. If someone went from here to Perth would three days be enough!? I don't think so... (Interview Data, Aboriginal Organization).*

*I don't think ... [the students] will be back...it's better they find out this way, I guess, although I think there's the potential in a short space of time for the negative stereotypes to be reinforced, like it was obvious that they noticed the rubbish around town, everybody does...they hadn't been out bush before so I think they were pretty shocked...so there's the likelihood certain stereotypes will be reaffirmed rather than contradicted by their [short] experience here... (Interview Data, Education Facility).*

The short duration of the placement period was the most consistently described Program limitation. Other concerns were that the students sometimes seemed under-prepared for

Program involvement and that a formal 'debrief' for both students and hosts should have been built into the Program's timeline before it concluded. Some hosts were unclear about what constituted their legal 'duty of care', especially in circumstances where inexplicable student behaviour caused them some anxiety, especially on cattle stations where it was possible that occupational health and safety issues could arise.

Not unusually, the evaluation process also resulted in a number of complex matters that had broader implications both beyond and within its purview, such as the role of overseas trained doctors and their relationship to remote communities, and the need to increase the number of Aboriginal doctors<sup>30</sup>.

## Conclusions

### *Continuity...*

Evaluation of NDU's Kimberley Remote Area Health Placement Program revealed that most Kimberley women and men who were formally interviewed and/or informally consulted claimed that it was a 'good' or 'great' idea. Reasons included the view that the Program might result in at least one good doctor returning to work in their own or another regional area. Interviewees and others consulted maintained that the Program introduced students to cross-cultural settings and a sense of community, as well as the beauty of the Kimberley environment and lifestyle, qualities that they hoped would facilitate the students' return. As stressed by a number of people, even if the students chose not to work in the Kimberley, then at least they would be better informed when someone from 'the bush' became a patient in, say, an urban-based hospital. Others emphasized that medical students would be in a better position to understand how and why some people became sick before they were hospitalized, and that the contact with students encouraged them to be reflective about their own practice, especially with regard to the conditions in many Aboriginal





communities. A consistent finding was that the Program should be continued, albeit with a few changes.

Despite the emphasis on the Program's benefits, some limitations were recorded alongside suggestions for change. The main concern was the short duration of the student placement, with the majority of interviewees arguing that it should be extended to at least one week. Such an extension would allow students to become a little more familiar with a complex region during the working week and the weekend, even though for some hosts this would pose an additional burden on an already heavy workload. Others believed that this would allow time for discussion and debate about the spectrum of socio-cultural and economic issues to which students were being introduced. That the students could have been better (more specifically) prepared about Kimberley health, medicine and history before participating in the placement was also raised by a small number of persons consulted.

### *...and change*

As a result of this evaluation, the 2009 Program has been improved by communicating the Program's purpose and the procedure to follow if a student 'misbehaves' to placement hosts more clearly and explicitly, on multiple occasions and in both verbal and written formats, building more structure and formality into students' preparatory sessions, sending each host a certificate of appreciation, formalising the SoM's requirement for individual students to make contact with their host after returning home, and by negotiating with the Medical Student Association of Notre Dame to communicate formally with all placement hosts at the completion of the placement. The 2010 Program has been further improved by extending the placement to include one day of leisure time with their host.

Overall the Program was undoubtedly conceptualized by Kimberley individuals as something that had strong potential to bring about a greatly needed change in the health of women, men and children. People's practical experience, combined with their heartfelt views, reflect the extent and

urgency of their concern, a point crystallized in the words of a Kimberley interviewee as quoted above and returned to here: 'If only one good doctor comes from the Program, then that's a good thing. A good doctor would have a great impact – the implications are immeasurable...'.

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