# A day in the life of a rural generalist

Mar 31, 2019 | 2
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When I started medical school, I didn't know that rural generalism existed as a potential career pathway. The Australian College of Rural and Remote Medicine (ACRRM) had only just started, and whilst generations of doctors were already working as rural generalists, the term "rural generalism" perhaps had not been formally coined. With growing recognition that the needs of rural communities required their doctors to have a relatively broad scope of practice with an understanding of the rural context, the concept of the rural generalist was established and defined. The goal of being able to tailor training of GP registrars to meet the needs of the rural community was met either through ACRRM or RACGP.

## My first exposure to Indigenous and rural medicine

Growing up, my experience with rural Australia was limited. I was born and bred in Melbourne to Chinese-Vietnamese refugee parents, and Chinese-Vietnamese suburban Melbourne was what I knew. It was the John Flynn Scholarship offered in med school that first exposed me to indigenous and rural medicine – in Cooktown. Some of my memorable experiences up there included putting a cannula into a dog to put it down (the bottle read 'BARB-A-KILL'!), seeing an envenomated snake handler lose consciousness rapidly in front of our eyes and attending a hens' night of the niece of prominent Indigenous activist Noel Pearson.

I had a fantastic time, but didn't understand that much about the importance of primary healthcare and there was also an element of my ego telling me that it wasn't good enough, to 'just be a GP'. This attitude was also probably subtly propagated by the culture at an adult tertiary hospital in Melbourne I worked at during internship. I liked using my hands, but enjoyed medicine. Critical care medicine was exciting, but palliative care was also rewarding. Then there was the lure of Far North Queensland and indigenous health far away from sight but never far away from my heart, and with that, my then-boyfriend (now husband) and I left for Cairns the following year.

## Finding my tribe

In Far North Queensland, I think I found my tribe. The hospital rotations there allowed for a broader scope of practice, encompassing obstetrics and gynaecology, paediatrics, emergency, intensive care, anaesthetics and the rural rotations in Cooktown and at Thursday Island - amazing places to work. I fell in love with emergency medicine in Cairns and realised that my heart was in being a jack-of-all-trades, and found the mixture of critical care medicine superimposed onto the uniqueness of tropical

medicine in Cairns very interesting. The training program was also easy to get into, and my supervisor was intelligent, quirky and approachable, and so I entered emergency medicine training in my resident year without much hesitation.

Two years later, we moved back to Melbourne due to family reasons. I worked in a tertiary trauma centre as an emergency registrar for two years. I found the work very stimulating, not just learning about clinical medicine, but also about how to manage a busy emergency department. However, the call of rural and remote medicine was consistently at the back of my mind. I also found myself doing less clinical work and managing more patient flow, and having a lot of arguments with inpatient teams along the way. After two years, I contemplated a career change.

## Volunteering overseas

After doing a diploma of obstetrics, my husband and I volunteered at a rural hospital in South Africa for six months. We were working with doctors who could intubate, do amputations, manage complex patients with HIV and TB, work in maternity, do their own growth scans, run a high dependency unit, and manage premature babies and very sick children. Each doctor, in addition to working in emergency, had their own ward to cover. Mine was mainly maternity – and in this small rural hospital in South Africa, there were 2000 births a year, with a 40% prevalence of HIV in the community.

I would do my own spinals, then scrub up to do a caesarean. There was certainly some sadness, but also a sense of thrill, purpose and intertwined amongst all this, a lot of hope. South Africa helped me to see with clarity that my heart was with rural generalism, and when I came home, I enrolled straight into ACRRM. I was lucky to have a lot of training time retrospectively accredited, as I also came home from South Africa pregnant, and in spite of dropping back to part-time since having had children, I was able to get through my fellowship in two years.

## Life as a rural generalist

Now, five years later, I have a hobby farm overlooking some magnificent green rolling hills, and I live with my husband, three boys, twenty-eight cows, a handful of sheep, five chooks, a rooster and a dog. It is clear that I'm originally a city girl, as I still find writing the above a real novelty! I work two days in the country general practice clinic and cover the hospital for obstetrics on call once a week. I do a bit of teaching and also the occasional locum work up north.

This helps to satisfy my yearning for working in indigenous health, and we get to work with some fabulous doctors, and see examples of remarkable leadership, often in people younger than me. Thursday Island is the epitome of rural generalism – the opportunities to work across public health, primary health care, emergency medicine, international health, retrieval medicine, obstetric and anaesthetic care in a remote setting are tremendous. That, on top of being flown in a chopper with you and the pilot over the Great Barrier Reef, spotting dugongs on the way to work. What is there not to love?

## Rural general practice

Perhaps not as glamorous as up north, but as I get older, the more respect I have for my GP colleagues in my country town, some of whom have been at our practice for more than twenty years. One of the owners does general practice, obstetrics, anaesthetics and emergency medicine and is still on the on-call roster after nearly thirty years. He is still enthusiastic about his job, but admits that he is feeling a 'bit tired'.

I think the new generation of rural doctors are less keen or willing to do this anymore, and I have met several younger doctors who are coming up with ways to commit to owning a practice, whilst also maintaining a work-life balance. I'm not sure that it's for me at this stage, but I think it can be done. If life has taught me anything about rural generalism, it is to think outside the square. If you think there's a problem with an existing system, there is always an alternative to do things differently.

Nothing has knocked me off my pedestal and engaged me more with working in primary health care than when I became a pregnant patient, and then a parent. Life truly has become messy now, and in the process of being forced to accept it, I have paradoxically come to embrace it and be more flexible to things that don't come packaged nicely. Patients are a good example of this.

## Managing the messy uncertainty

For every appendicitis that makes it to the surgical registrar's hands with textbook signs of an acute abdomen, there are hundreds more that don't fit neatly into a diagnosis and I am learning that the key to managing the anxiety behind the uncertainty for both doctor and patient is to stop talking, listen more and try to really see the person behind the symptom. Speaking of appendices though, I remember in my earliest days as a GP registrar, diagnosing a 22-year-old with appendicitis in my morning session, taking out his inflamed appendix with the GP surgeon in my lunch break, seeing him the next day on the ward and discharging him from the hospital, and then following him up back at clinic the next week, 100% better and very grateful.

This year, I was seeing a couple who was pregnant, and the partner said I looked a bit familiar. Turns out, he was the young man whose appendix we had taken out 6 years ago!

## Being a GP

I think being a GP is a bit like being a parent. To the outsider, on paper, what you do and deal with can seem quite mundane, yet the immense rewards and wholeheartedness lie in your ongoing relationships, and often the most heartfelt times are in the most quiet, most ordinary moments. Working with your patients through their lifestyle can be some of the challenging journeys, as is negotiating with your children. Nursing your child off to sleep, feeling the intense connection that comes with watching them after a long, tiring day, is not that dissimilar to holding the intensity of support and validation for a patient who is working through their news of having cancer.

I know why some doctors don't like dealing with messy, and on a given day, neither do I. But ultimately, I know that if I lean into the discomfort of the messiness, and be a coach

for some of my patients through their weight loss or mental health battles, that a lot of their health issues will disappear.

## Cradle to grave medicine vs hospital medicine

Hospital medicine sometimes feels like bandaid medicine, and although the critical care component can be exciting, there are also the frequent presenters with worsening chronic disease, drug and alcohol and mental health issues who are the source of despair. Sometimes you see the extremes in hospitals but often not the quiet achievers and the big leaps of achievement that come with little steps, the journey which you are privy to in general practice. Maybe I'm biased, but I think the biggest gains and cost-effectiveness in health outcomes stem from good primary health care and preventative medicine. And to do that, you need to walk the walk with patients alongside them.

I have been doing GP obstetrics over the last seven years, and have also had time off to have 3 children over the last five years. This means that some of my pregnant women and I have been tag-teaming with our pregnant bellies and our births and maternity leave. I am yet to deliver a baby of one of my babies like some of my more experienced colleagues, but I have delivered a few of my women's third babies, and that is pretty special.

Cradle to grave medicine, exploring the art of medicine as well as the science of medicine, learning to adapt and remain flexible when not all the resources are at your fingertips, the natural link to international health, having continuity of patient care and being taught every day about connection and humanity in medicine: that's why I love rural generalism. If anything of this appeals to you at all, please do not hesitate to contact me.

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