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CONFERENCE REVIEW

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7th Annual WONCA Rural Health Conference 2006

WONCA – (World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians)
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Held at University of Washington, Seattle, School of Medicine, (home to the WWAMI medical education program - *Washington*, *Wyoming*, *Alaska*, *Montana*, *Idaho*), which has seen 35 years of successful education for medical graduates in rural areas within the United States, [1,2] the theme of the 7th Annual WONCA Conference was "Transforming Rural Practice Through Education".

Objectives of the conference included discussion of current policy issues relevant to world wide rural primary care; recognition of current areas of clinical and health services impacting on rural primary care; utilization of new approaches in education; discussion of major threats to the health of rural populations; and discussion of current research in rural healthcare education and policy development.

Professor Judith Walker (University of Tasmania), Associate Professor Peter O'Meara (Charles Sturt University), and myself (Tasmanian Ambulance Service) presented one of the sessions, titled *The Rural and Regional Ambulance Paramedic: Moving Beyond Emergency Response.* This was a report of results from the most recent and extensive research into the practices of Australian rural ambulance paramedics, and had been conducted across the states of NSW, Victoria, Tasmania, and South Australia.[3]

Being invited to attend the conference as a paramedic research assistant, I was sponsored by the Council of Ambulance Authorities (CAA), which was also responsible for the commissioning and funding of *The rural and regional ambulance paramedic: Moving beyond emergency response.*[3]

The project was of interest to WONCA in that it involved research into the extended scope of practice by rural paramedics in Australia. Paramedic research assistants were drawn from the study sites in NSW, Victoria, SA, and Tasmania, and results indicated a new model for rural paramedical practice with four core activities - Rural community engagement; Emergency response; Scope of practice extension; and
Primary health care. Hence the acronym RESP. Fundamental to the RESP model of practice is a sound foundation in education and training.[3]

An emergent theme at the conference was of Australia as a world leader in development of rural health education for medical personnel and in developing innovative programs and initiatives to help rural doctors. Changing the face of rural medicine in Australia was the rural doctors dispute of 1987/88 in which rural doctors took industrial action against the state government. The Rural Doctors Association of NSW was formed in 1987 as a result of a doctors dispute in that year and has since been an effective political lobby group. Other states were to follow, and the Rural Doctors Association of Australia was established in 1991. As a result, federal, state and territory governments in Australia have funded strategies to improve retention and recruitment of rural doctors.[4]

Recent examples of universities establishing specific faculties for rural health education also come from Australia. Following plenary presentations, the opening session at the conference discussed how the Faculty of Health science (Medicine, Nursing, Paramedicine, Biomedical Science and Human Life Science) at the University of Tasmania has put into place strategies to "ruralise" Health Science courses. An unexpected outcome has been that the rural based curriculum, research and clinical services now influence the urban setting. Some main outcomes have been increased numbers of students undertaking rural placements, rural context a regular feature of case based learning, senior academics located in rural schools, high quality clinical education infrastructure in rural and remote sites, and rural health research findings influencing statewide policy directions.[5]

The University of Western Australia's Rural Clinical School introduces medical school students to rural health services, and aims to increase their cultural awareness by educating them for one full year in rural Australia. So far the school has accepted 83 students over its first 3 years of operation. Important to the function of rural placement are the rural doctors and other health professionals who act as both role models and mentors. With year long placement the ability to integrate within the community has been important, as has support from the academic institution. Curriculum and on line resources are optimized for a rural context.[6]

The success of the medical education and training services of Queensland's Rural Workforce Agency was also discussed. During the years 2004 – 2005, as a result of specific education programs for rural doctors, high proportions of participants indicated they were more likely to remain in rural practice; the programs alleviated professional isolation; they had more confidence in practicing in rural/remote areas; and the education programs were relevant to their learning needs.[7]

Experiences from other countries helped place rural medical practice in a global perspective. One enlightening session, also mirrored in a plenary presentation,[8] was in regard to training in family medicine within the Philippines. There are several reasons for not wanting to take up rural practice, including poor financial compensation, paucity or absence of continuing medical education, emotional or physical demands of rural practice, multiple roles or responsibilities, political instability and infighting, exodus of professionals to Western countries, spousal discontent, and/or childrens' education.

However, following a survey conducted at Ateneo de Zamboanga University School of Medicine, the main concern expressed was for a referral system and career pathway progression to further community interest and passion. A program was developed in which trainees are not removed from their rural practice commitments but allowed to remain in their current areas of service. Clinical work done in respective communities becomes a significant

part of training, thus the curriculum is tailored to fit the individual needs and interests of the communities served. Supervision is by distance communication, mobile phones, text messages, couriers, and on site family practice preceptors. The program is proving to be most successful with graduates in Family Medicine choosing to stay on in their respective communities.[9]

Illustrating the importance of training specific to community circumstances was the session covering relatively recent immigration from Ethiopia to Israel, of around 600 people every month. After placement in absorption centers for the first two years the immigrants are then moved to permanent housing. With some absorption centers in rural areas Dr. Assi Cicurel discussed the need for rural practitioners to now be skilled in special medical aspects applying to this population group. These new skills range from an awareness of cultural beliefs such as witchcraft, bloodletting, removal of uvula in infants; to differing blood counts, with benign leucopenia, almost universal eosinophilia; and intervention for parasitic infections, fungal infections, TB, and HIV.[10]

With often centralized training and education, but with diverse spread of services, paramedical educators could learn from the experiences in delivery of continuing education, and several sessions dealt with this topic. One of these mentioned the Australian Rural Health Education Foundation (RHEF) (www.rhef.com.au), established in 1992. In recognition of a need for high quality continuing medical education (CME) to improve rural recruitment and retention of doctors and other health professionals, the RHEF used satellite television and more recently web-streaming, pod casting and DVD/video to deliver free distance education services.

Initially dependant on funding from pharmaceutical and other sponsorship the foundation is now self sustainable through funding from government and national health organizations. The audience has diversified to include most non-doctor health professions.[11]

Again, on use of electronic media, David Topps of the Northern Ontario School of Medicine (NOSM) discussed how a new medical curriculum introduced in 2005 to the NOSM found online medical resources crucial to the program. His session covered the use of open and free software options for students such as “Wikiversity” which can support collaborative note taking and generate widely accessible shared information. The use of wikis, through sites such as http://en.wikiversity.org, personal blogs, online library services such as www.librarything.com and online bookmark services such as http://del.icio.us were discussed. Students had found these sites useful means of locating and sharing information.[12]

Some sessions at the WONCA conference were specific in covering different aspects of medical practice in rural areas, from disease management, to use of available technology in assisting diagnosis, and rural practitioners with special needs.

Tackling special needs from an interesting perspective Malgorzata Kaminska discussed the barriers facing disabled rural physicians, and suggests that creation of new rehabilitation programs and attitudinal changes are necessary to retain these highly skilled professionals in rural areas. Attitudinal barriers involve paternalism, lack of equal opportunity, and assumptions of incompetence. Other barriers include lack of confidentiality, and reduced disability support in rural areas.[13]

Results of one study were presented suggesting that differences in how doctors and patients view diabetes may delay or even prevent the commencement of insulin. Doctors’ main barriers against commencement of insulin in patients requiring it were assumptions regarding

patient compliance, hypoglycaemia, coping with the pain of blood tests, and coping with the pain of injections. In contrast, pain of injection and blood tests ranked low among patients. Their main concerns were in regarding the illness as not very severe, and fears of addiction to insulin. The lesson for all medical practitioners, including paramedics is to be acutely aware of patient perceptions.[14]

One very interesting session perhaps has implications for future paramedical assessment of trauma in rural and remote areas, and covered the administration of ultrasound as an adjunct to clinical judgment in the diagnosis of trauma.

The decision to arrange for rapid evacuation of a patient following trauma can be assisted by using ultrasound to examine for the presence of abnormal fluid, and in determining whether intra-abdominal bleed or cardiac tamponade is the cause of shock.

Michael Jong demonstrated on himself and had others use the device to examine the hepatorenal space, splenorenal space, and the pericardial space. Novice users were able to quickly identify the features with very little instruction.[15]

The 7th annual WONCA Rural Health Conference certainly met its objectives, and from the perspective of a paramedic research assistant, was highly beneficial on several fronts. Being invited to present *The rural and regional ambulance paramedic: Moving beyond emergency response* indicates a recognition of the rural paramedic as one component of rural health practice. The sponsorship by the CAA of a paramedic researcher to co-present findings is a distinct promotion of paramedical practice as a respected health care profession. The WONCA Rural Health Conference served to illustrate where rural medical practice is currently placed in the global arena, paramedical practice can develop using these experiences, and grow as an integral part of the rural health care team.

References

1. Ramsay, P.G., et al., *From concept to culture: The WWAMI program at the University of Washington School of Medicine.* Academic Medicine: Journal of the Association of American Medical Colleges, 2001. **76**(8): p. 765-775.
2. Norris, T.E., et al., *Regional solutions to the physician workforce shortage: The WWAMI experience.* Academic Medicine: Journal of the Association of American Medical Colleges, 2006. **81**(10): p. 857-862.
3. O'Meara, P., et al., *The rural and regional ambulance paramedic: Moving beyond emergency response,* in *Report to The Council of Ambulance Authorities Inc*. 2006.
4. McEwin, K. *The rural doctors movement in Australia*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
5. Walker, J. *Changing the agenda: Ruralising an urban-centric university health science faculty*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
6. Murdoch, J.C. *Key essentials in establishing a rural clinical school*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA. USA.
7. Mitchell, C., L. Green, and C. White. *Making a difference - Education and training retains and supports rural and remote doctors in Queensland, Australia*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
8. Cristobal, F. *The Asian experience*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
9. Afdal, K., et al. *Alternative residency training program for rural physicians: a Philippine perspective*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
10. Cicurel, A.A. *From Ethiopia to the desert - a country doctor's notebook. Medical aspects of immigration from Ethiopia to the Israeli rural desert.* in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
11. Perglut, D. and A. Little. *Maximising educational access for rural and remote health professionals: responsive business an technology models for continuing medical education*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
12. Topps, D. *Sharing medical educational resources using free and open-source software*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
13. Kaminska, M. *Tackling the stairs/stares: identifying the environmental and attitudinal barriers faced by the physically disabled rural physician.* in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
14. Vinker, S. and G. Yitzhaki. *Transition to insulin in Type 2 diabetes: Family physicians' misconceptions of patients' fears contributes to existing barriers*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.
15. Jong, M. *Ultrasound in the assessment of trauma*. in *7th Annual WONCA Rural Health Conference - Transforming Rural Practice Through Education*. 2006. Seattle, WA, USA.