

Training for Rural General Practice

**World Organisation of
Family Doctors**

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POLICY ON TRAINING FOR RURAL PRACTICE

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WORKING PARTY MEMBERS

Professor R Strasser - Australia, Convenor*
Dr J Rourke - Canada*
Dr I Anwar - Pakistan*
Dr N Naidoo - South Africa*
Dr H Rabinowitz - United States of America*
Dr J McLeod - United Kingdom*
Dr P Newbery - Canada*
Dr T Aziz - Pakistan
Professor R Rosenblatt - United States of America
Professor SH Lee - China (Hong Kong)
Dr J Wynn-Jones - United Kingdom
Dr MK Rajakumar - Malaysia
Professor Gu Yuan - China
Dr B Chater - Australia
Dr T Doolan - Australia
Dr J Cowley - Ireland
Dr C Simpson - United States of America

* denotes original working party members

ENQUIRIES REGARDING THIS POLICY SHOULD BE DIRECTED TO:

Professor Roger Strasser
Director, Monash University Centre for Rural Health
Locked Bag No 1. Moe Victoria 3825 Australia
Telephone: + 61 51 270 735
Facsimile: + 61 51 270 737
Email: roger.strasser@med.monash.edu.au

SUMMARY

The worldwide shortage of rural family doctors contributes directly to the difficulties with providing adequate medical care in rural and remote areas in both developed and less developed countries. WONCA believes there is an urgent need to implement strategies to improve rural health services around the world. This will require sufficient numbers of skilled rural family doctors to provide the necessary services. In order to achieve this goal, WONCA recommends:

1. Increasing the number of medical students recruited from rural areas.
2. Substantial exposure to rural practice in the medical undergraduate curriculum.
3. Specific flexible, integrated and coordinated rural practice vocational training programs.
4. Specific tailored continuing education and professional development programs which meet the identified needs of rural family physicians.
5. Appropriate academic positions, professional development and financial support for rural doctor-teachers to encourage rural research and education.
6. Medical schools should take responsibility to educate appropriately skilled doctors to meet the needs of their general geographic region including underserved areas and should play a key role in providing regional support for health professionals and accessible tertiary health care.
7. Development of appropriate needs based and culturally sensitive rural health care resources with local community involvement, regional cooperation and government support.
8. Improved professional and personal/family conditions in rural practice to promote retention of rural doctors.
9. Development and implementation of national rural health strategies with central government support.

1. INTRODUCTION:

Every rural practice is unique with its own challenges and rewards. A variety of definitions is used around the world depending on local context. In Australia, the RACGP Faculty of Rural Medicine defines rural practice as medical practice outside urban areas, where the location of the practice obliges some general practitioners to have, or to acquire, procedural and other skills not usually required in urban practice.

There continues to be a worldwide shortage of family doctors (general practitioners) in rural and remote areas, and in particular doctors with the necessary skills and knowledge to work effectively and comfortably in these areas. In less well developed countries the majority of the population is located in rural areas that may lack basic health requirements such as clean water, adequate food and shelter, and where at best they have limited access to modern medical services. Developed countries also have significant shortages of rural family doctors, even in countries where there is an overall over supply of doctors.

People living in remote and rural communities require the security of ready access to medical care at times of serious illness or injury. In addition, doctors and hospitals in rural communities are important to the local economic and social fabric. Often the health status of special needs groups is worse in rural than metropolitan areas. These include the poor, the elderly, women and indigenous people. Establishment of family doctor services supported by hospitals and other health facilities provide the basis for developing primary health care and health promotion programs.

It is well recognised that the provision of medical services by broadly trained generalist family physicians is more cost effective than a range of specialist practitioners and others providing primary care. In addition, for developing countries, improvements in health status and economic development are closely linked. Consequently, it is important that all nations adopt specific policies and programs aimed at improving rural health services through increasing the numbers of broadly skilled family physicians located in rural and remote areas.

2. ADVANTAGES OF RURAL PRACTICE:

Rural doctors identify a series of key attractions of rural practice. First is the greater variety of practice that often includes obstetrics, surgery, anaesthetics and emergency medicine together with hospital access and care of the acutely ill. Rural practitioners are much more likely to be looking after individual patients for all of their medical problems on a continuing basis and to be caring for other family members. Thus comprehensive and continuing care are frequent realities in the country.

For many rural doctors the second great attraction of rural practice is the country environment and lifestyle which is associated with a better family life in a good place to raise children particularly in developed countries. Social satisfactions of rural practice identified by rural doctors include community standing and respect, coupled with a sense of belonging to a stable community, and enjoyment of outdoor living with many recreational opportunities. In short, rural practice can offer considerable

professional rewards and satisfactions coupled with the attractions of significant social status away from the difficulties of city living.

3. BARRIERS TO ENTERING RURAL PRACTICE:

A number of attitudinal and perceptual barriers have been identified as discouraging medical graduates from entering rural practice. Some of these are misperceptions and others have a basis in reality. The key misperception is that rural practice is somehow "second class medical practice". Most undergraduate medical students have a city background and so have no personal experience of living and working in the country. In addition, most of the senior teachers in medical schools have an experience and view of medicine which sees teaching hospital practice as the ideal. Consequently, they assume that medical practice in rural areas without the same facilities and support as teaching hospitals is of a lesser standard.

An important attitudinal problem is that of "learned helplessness". The highest that many new medical graduates aspire to in dealing with medical problems is being able to assess to which specialist to refer the patient. Consequently, it is a frightening prospect for them to contemplate rural practice where they have to manage problems themselves without immediate access to high technology medical facilities and specialists.

There are a number of other barriers which add to the disincentives for new graduates contemplating rural practice. These include the heavy workload and long hours on call which are likely to continue while there is a shortage of doctors in the country. A lack of infrastructure and regional support is common to rural practice, especially in developing countries. Also, the relative professional isolation, which provides many challenges and rewards for rural doctors is seen as a negative factor for many students and new graduates. Often this aspect is over-emphasised within the context of urban-based training rather than the development of individual knowledge and skills required and organisational strategies to address rural health needs.

As well as the professional disincentives to rural practice, there are personal and family issues as well. Rural practice, particularly in small communities, may be difficult for the doctor's spouse. Often the spouse is treated differently from other members of the community and may become personally isolated. Employment for the spouse and education for the family are often significant problems in rural practice. Arrangement of locum relief to permit holidays and continuing education is often a major difficulty.

Even for those students and recent medical graduates who wish to enter rural practice, there are difficulties in obtaining appropriate training and ongoing educational support. Tailored training programs preparing medical graduates for rural practice are relatively few. Once in rural practice not only is continuing education difficult to arrange, but often proves to be of limited value to practising rural doctors. Generally, the knowledge and skills acquired through experience in rural practice are not given due recognition. This limits the potential for career development of doctors who choose to practice in country areas.

Drawing all these factors together it is not surprising that in the view of many undergraduates and new medical graduates the professional and social advantages of rural practice are overwhelmed by the disadvantages. In order to overcome these problems there needs to be developed a series of comprehensive strategies which address all the specific issues. This policy document has been developed drawing on the experience in many countries around the world and forms the framework for a comprehensive strategy plan to improve the recruitment and retention of rural family physicians.

4. RECRUITMENT AND RETENTION OF RURAL FAMILY PHYSICIANS:

The ultimate goal of this policy is for there to be sufficient numbers of skilled doctors located in rural and remote areas to meet the health service needs of the people they serve. Although the primary focus of the policy is on education and training for rural practice, this should be seen in the wider context of recruitment to and retention of doctors in rural practice. There is a need to establish an integrated career pathway of education and training for rural practice, beginning at the pre-undergraduate level and continuing through undergraduate medical education to specific rural practice vocational training followed by appropriate continuing and university graduate education, practice structures and family supports.

Ultimately, recruitment to rural practice will only increase when students and new medical graduates see rural practice as a positive career option. The series of strategies outlined in this document are intended to bring this about through sensitising students to rural medicine early on and providing appropriate clinical teaching in the latter part of the undergraduate course and in the immediate postgraduate period.

Retention in rural practice is likely to be improved through tailored continuing education and professional development programs, and the opportunity to pursue university higher education while remaining in rural practice.

In addition to education and training issues, there are a number of other factors which require attention in any program to improve recruitment and retention to rural practice. Reasonable working conditions, including a balance between workload, on call and free time, are essential. Reliable cross coverage or locum relief is a fundamental issue. Also there needs to be appropriate financial reward for the complexity of the services provided and degree of clinical responsibility taken by the doctor. Other financial aspects include additional costs of living in rural communities with the need for transportation to larger centres for continuing education and professional development. Providing a good education for the doctor's children can be difficult and costly.

Also, retention of rural doctors depends greatly on the satisfaction of the physicians spouse and family. Often the reasons for rural practitioners returning to the city relate to spouse and family concerns. Consequently, these are given specific attention in this policy document.

5. UNDERGRADUATE EDUCATION:

Experience around the world shows that students from a rural origin are much more likely to enter rural practice after graduation. In most current medical courses, the proportion of students from a rural origin is significantly less than the proportion of the population which lives in the country. Clearly one important strategy for increasing the numbers of rural doctors involves recruitment of more medical students from a rural background.

In order for this to occur, secondary students in rural areas need to be encouraged to consider medicine as a career option and to apply for entry to medical school. Consequently there is a need for specific programs which promote medicine to rural secondary schools. In many rural areas the academic standards of the secondary schools may not be sufficiently high for their graduates to qualify for medical school entry. Thus, programs need to be developed which identify potential medical students and assist them with secondary education in preparation for medical school entry.

In order to ensure an appropriate proportion of rural origin students are recruited into medical schools, there need to be specific mechanisms included in the selection process. Criteria for selection based on marks plus other criteria are evolving. Selection processes which include interview of applicants and give recognition and credit for rural background are to be encouraged. Specific targets for admission of students from a rural background may be needed.

After a rural background the next strongest factor associated with entering rural practice is undergraduate and postgraduate clinical experience in a rural setting. Consequently, rural exposure for all undergraduate medical students should be maximised. Early positive exposure to rural practice will encourage more students to develop an interest in rural practice as a career option and foster a better understanding of rural practice for others. All students should be introduced to rural health issues early in the medical course and have clinical rotations to rural hospitals and rural family practice later in the course.

As rural practitioners provide a wider range of services than their metropolitan counterparts, rural practice attachments provide students with the opportunity to develop a breadth of clinical skills. These include diagnostic and therapeutic procedural skills as well as skills of clinical judgement and self reliance in the practice setting. This rural experience also helps students identify their own learning needs.

In addition, students should be encouraged to undertake optional attachments and electives in rural health, ranging through rural hospital attachments, rural family practice and other rural health services.

"Rural Practice Clubs" encourage city origin students to develop an interest in rural practice and support rural background students in adjusting to the challenges of city living and university studies. Rural origin students would be assisted further through rural doctor mentor schemes whereby each student is attached to a physician practicing in the rural town or area from which the student comes. The mentor

provides the student with ongoing personal support and encouragement as well as a professional role model.

For students who indicate an early commitment to rural practice then a "rural medicine stream" in the medical school is recommended. This might take the form of one to three years of the complete medical curriculum undertaken in the rural setting, or a thread of rural attachments intertwined through the clinical components of the curriculum.

Decentralised medical schools that allow medical students to take a major part or all of their studies at centres located outside major metropolitan areas, are more likely to attract students from rural areas and be successful in producing doctors to practice in rural areas.

The development of community based family medicine curricula in medical education should be encouraged, and should include significant rural content.

Medical schools should assume a responsibility to educate appropriately trained doctors to meet the needs of their general geographic region including underserved areas. As well, they should play a key role in providing regional support for health professionals and accessible tertiary health care. The inclusion of rural doctors as educators and researchers is integral to the development of an improved understanding of and a supportive attitude towards rural practice.

The development of undergraduate and postgraduate education and training for rural practice is greatly facilitated by the establishment of Rural Medical Education Centres. These Centres should be established in rural areas with the aim of co-ordinating undergraduate education, vocational training, continuing education and university postgraduate studies for rural doctors. An important function of these centres is to facilitate the development of reciprocal links between rural hospitals/practices and medical schools/teaching hospitals. The establishment of such Centres provides the opportunity for rural family physicians to be actively involved in teaching students and vocational trainees. They also provide a focus for other academic developments including rural health research.

6. POSTGRADUATE VOCATIONAL TRAINING:

Rural family physicians generally provide a wider range of services than do their metropolitan counterparts. Consequently, there is a need for specific residency training programs for rural practice which prepare new medical graduates for a career in the country.

Wherever possible, training for rural practice should occur in the rural setting based at regional rural hospitals and rural family practices. In addition to standard training for family practice, rural practice vocational training requires specific emphasis on: hands-on learning of procedural skills; the spectrum of illnesses in rural and remote communities; the sociology and psychology of rural and remote communities; and professional and personal aspects of living and working in small rural communities.

Training positions for advanced rural practice skills in emergency medicine, anaesthesia, surgery, procedural obstetrics and others, need to be developed and appropriately funded. Depending on the intensity of the training program, such training may involve one to two years of additional training time over and above basic family medicine training.

Consideration should be given to recognition for rural vocational training in the form of certification in rural medicine. The opportunity to take some training in other countries can broaden experience and help develop new approaches to medical practice, medical education, and health care delivery.

7. CONTINUING EDUCATION AND PROFESSIONAL SUPPORT:

Most rural practitioners experience great difficulty in arranging locum relief to attend continuing education activities. Often rural family physicians find that when they do attend continuing education programs that they are of little value to them as they are not pitched at the appropriate level.

There is a need for specific tailored continuing education and professional development programs to meet the needs of rural family physicians. Generally these programs should be developed by rural doctors for rural doctors. Rural Medical Education Centres provide a very appropriate focus for developing such continuing education programs.

These programs should recognise the pre-existing knowledge and skills of rural family physicians which have often been developed through dealing with clinical problems in relative professional isolation, rather than through formal training. The programs should be responsive to the specific learning needs of the doctors which usually involves a focus that is practical, case based and problem oriented. The aim of such continuing education programs should be to empower the learner and thus extend and expand the doctors knowledge and clinical skills.

Continuing education program should also be accessible to rural practitioners which means locating them in rural regional centres rather than major cities. Also, the use of distance education methods to bring continuing education to rural practitioners is to be encouraged. This includes not only traditional published materials, but also the use of new technologies including teleconferencing, electronic mail and satellite television, and other developments in modern information technology.

Another important form of continuing education and professional development is short term hands-on clinical attachments in larger hospitals. These should be encouraged and facilitated through liaison with the specialists in these hospitals. Release from the practice maybe facilitated by rotating locum relief schemes where a group of rural practices share a rotating locum.

The opportunity to do sabbaticals or exchanges in other countries can broaden experience for practicing rural doctors and help develop new approaches to medical practice, medical education, and health care delivery.

8. HIGHER UNIVERSITY STUDIES:

Currently there is no sense of career progression for doctors who go into rural practice and those who later wish to pursue an academic career are given little credit for the knowledge and experience gained while practicing in the country. There is a need to develop appropriate university postgraduate diplomas and degrees which would provide a means for career progression into education, research or administration. Also such graduate studies programs would assist in creating a pool of academically trained rural practitioners to staff Rural Medical Education Centres and other rural health academic units.

For such postgraduate studies to be of value to rural family physicians they must be offered by distance education. The use of distance education allows rural doctors to pursue higher studies while staying in their practices and towns.

9. FINANCIAL AND MATERIAL SUPPORT:

As mentioned previously, practice in remote and rural areas has many financial disadvantages. In order to recruit and retain doctors in remote and rural practice these financial issues need to be addressed. This may take the form of additional payment recognising the higher level of clinical responsibility and services provided; specific incentive payments for practicing in underserved areas; financial assistance with accommodation, education and travel for the doctor and his/her family; and so on.

Another form of material support is the provision of premises and equipment for the medical practice. Many rural communities provide such facilities to assist in attracting doctors.

A physician is more likely to remain long term in a rural practice where he or she is not the sole provider of medical services. Consequently, two or three doctor group practices are to be encouraged where necessary through direct financial support so as to sustain the economic viability of the practice. In order to provide effective primary health care, rural doctors require the assistance of appropriately trained nurses and other health professionals. Combining facilities for doctors and other health professionals in rural community health centres fosters cooperative health care delivery.

After a doctor, the next health service priority for a rural community is a hospital which provides acute medical, surgical, obstetrics and paediatric care. Many such hospitals have been constructed and equipped with considerable financial support from the local community. The hospital is important also to the economy of the town as a major employer and purchaser of goods and services within the community.

Rural family doctors require facilities and privileges to provide the needed services for which they are trained and competent. Undue hardship on rural communities may result from imposition by central regulatory authorities of excessive certification or fellowship requirements for performing procedures.

Overall health care delivery may be improved by networking among doctors and sharing health care facilities and professionals between several communities. There is a role for government to ensure that the health system provides appropriate physical facilities and services to meet the needs of rural and remote communities.

10. FAMILY AND SPOUSE SUPPORT:

For the rural family physician, there is a major challenge in being the confidential medical adviser in the consulting room and friend in the social and recreational setting in the community. For doctors' spouses this may be more difficult as members of the community will tend to treat them differently because of the connection with the doctor. In many ways, the rural practitioner's spouse may be more socially isolated than the doctor. Consequently, there is a need for specific strategies to provide personal support for doctors spouses. Also spouses often have difficulty in obtaining employment and/or pursuing career objectives. Strategies to meet these needs must be included.

For the doctor's family, there are difficulties with education and subsequent employment. Strategies to assist with educational support and funding for going away to pursue education should be included in support programs for doctors' families.

The long periods on-call with frequent call outs lead to great family disruption such that there is a need for longer than usual periods of recreation leave for rural doctors and their families. Programs to assist must include appropriate locum relief and financial assistance to permit recreation leave away from the rural community.

11. NATIONAL SUPPORT:

Central government support is essential to the provision of accessible health care particularly in rural underserved areas. National governments need to develop and implement effective national rural health strategies. This requires the cooperation of communities, doctors and other health care professionals, hospitals, medical schools, professional organisations, and governments. Rural health care should be well resourced and funding mechanisms should be developed which meet the needs of rural populations. Establishment of National Rural Health Research Organisations can facilitate this process.

12. CONCLUSION AND RECOMMENDATIONS:

WONCA believes there is an urgent need to implement strategies to improve rural health services around the world. In order to achieve this, there needs to be sufficient numbers of skilled rural family doctors to provide the required medical services. This document has outlined a series of key issues of concern regarding training for rural practice.

It has been found that the production of more and more doctors does not lead to an overflow of physicians from the cities to the country. In order to increase the numbers and quality of rural doctors it is necessary to implement a series of strategies aimed at establishing an integrated career pathway of education and training for rural practice. In the long term, it is only this strategic approach which is likely to improve the recruitment and retention of rural family physicians.

In order to achieve this goal, WONCA recommends:

1. Increasing the number of medical students recruited from rural areas. Strategies may include:

- 1.1 Introduction of programs promoting medicine as a career to rural secondary students.
- 1.2 Establishment of scholarships and educational support programs which identify potential medical students in rural areas and assist them with secondary and tertiary education in preparation for medical school entry.
- 1.3 Selection processes that encourage admission of students from rural areas.
 - 1.3.1 Selection processes including interviews should give specific recognition and credit for rural background, experience, and interest.
 - 1.3.2 Specific targets for students from a rural background may be needed.

2. Substantial exposure to rural practice in the medical undergraduate curriculum. This may be achieved through:

- 2.1 Establishment of "Rural Practice Clubs" which encourage city origin students to develop an interest in rural practice and support rural background students in adjusting to the challenges of city living and university studies.
- 2.2 Rural doctor mentor schemes which provide rural origin students with ongoing personal support and encouragement from a nominated rural family physician.

- 2.3 An introduction to rural health issues early in the curriculum including specific rural practice attachments for students early in the medical course.
 - 2.4 Block clinical rotations to rural hospitals and rural family practice later in the course.
 - 2.5 A rural medicine stream for a selected group of students who indicate an early commitment to rural practice. This might take the form of:
 - 2.5.1 One to three years of complete medical curriculum undertaken in the rural setting.
 - 2.5.2 A thread of rural attachments intertwined through the clinical components of the curriculum.
 - 2.6 Decentralised medical schools that allow students to take most or all of their medical school education in centres outside major metropolitan areas.
- 3. Specific flexible, integrated and coordinated rural practice vocational training programs. These programs should:**
- 3.1 Be needs driven, evidence based, and learner centred
 - 3.2 Have appropriate faculty, hospital, and financial support
 - 3.3 Provide particular emphasis on training in procedural skills and an appropriate core curriculum on rural practice in addition to a solid family medicine foundation
 - 3.4 Provide a major portion of training within the rural context
 - 3.5 Provide the opportunity and funding for advanced rural skills training in emergency medicine, anaesthesia, surgery, procedural obstetrics and others.
 - 3.6 Provide opportunities for regular family medicine trainees to experience the joys and challenges of rural family practice
- 4. Specific tailored continuing education and professional development programs which meet the identified needs of rural family physicians.**
- 4.1 Continuing medical education programs should be accessible to rural practitioners through locating them in rural regional centres and, where appropriate, making use of distance education methods including modern information technology.
 - 4.2 Generally rural continuing medical education programs should be developed by rural doctors for rural doctors.

- 4.3 Development of appropriate university postgraduate diplomas and degrees available via distance education so as to allow more remote rural doctors to pursue higher university studies without leaving their towns or practices.
5. **Appropriate academic positions, professional development and financial support for rural doctor-teachers to encourage rural health research and education.**
 - 5.1 Rural Medical Education and Research Centres should be established in rural areas with the aim of co-ordinating undergraduate education, postgraduate vocational training, and continuing medical education for rural practitioners. Such Centres greatly facilitate implementation of all previous recommendations. An important consequence of establishing Rural Medical Education and Research Centres is development of reciprocal links between country hospitals/practices and medical schools/teaching hospitals.
6. **Medical schools should take responsibility to educate appropriately skilled doctors to meet the needs of their general geographic region including underserved areas and should play a key role in providing regional support for health professionals and accessible tertiary health care.**
7. **Development of appropriate needs based and culturally sensitive rural health care resources with local community involvement, regional cooperation and government support.**
 - 7.1 Provide appropriate funding to develop and maintain hospital and other health services and referral resources to meet the needs of people in rural and remote communities.
 - 7.2 Establish rural community health centres with facilities and support for doctors and other health professionals.
8. **Improved professional and personal/family conditions in rural practice to promote retention of rural doctors. Strategies include:**
 - 8.1 Locum relief schemes should be established to permit release of rural family physicians to undertake continuing education as well as recreation and other forms of leave.
 - 8.2 Targeted financial support for rural practice such as:
 - 8.2.1 Funding models that provide security and flexibility for the doctor to and recognise the physician as a community resource.
 - 8.2.2 Additional payments to rural practitioners in recognition of the higher level of clinical responsibility, services provided and on call demands.

- 8.2.3 Specific incentive payments for practicing in isolated/underserved areas
- 8.2.4 Financial assistance to maintain the economic viability of at least two doctors working together in a rural location.
- 8.2.5 Funding for travel and other costs for the doctor to attend continuing medical education.
- 8.3 Specific programs to meet the needs of rural doctors' spouses and families such as:
 - 8.3.1 Spouse and family support networks.
 - 8.3.2 Financial assistance with accommodation for the doctor and family.
 - 8.3.3 Financial assistance to facilitate education of the doctor's family.
 - 8.3.4 Funding to permit travel by the doctor and family for recreation and other forms of leave and to visit family members undertaking secondary or tertiary education.
 - 8.3.5 Assistance in developing employment opportunities for the doctor's spouse.

9. Development and implementation of national rural health strategies with central government support. This requires:

- 9.1 Cooperative involvement of communities, doctors and other health care professionals, hospitals, medical schools, professional organisations, and governments at all levels. Establishment of national rural health research and education organisations can facilitate this process.

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This WONCA Policy is based on experiences in many countries around the world. The following list of references highlights key issues:

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An extensive list of published articles on education for rural practice has been collected, collated and annotated by Dr James Rourke. This publication "Education for rural practice: Goals and opportunities: An annotated bibliography", is available at cost through the Australian Rural Health Research Institute Moe, Victoria 3825 Australia.

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