

DEVELOPING THE MODEL: A PERSPECTIVE FROM THE DEVELOPED WORLD

Thirty years ago, as a second-year medical student, I spent a summer working with WHO in an isolated Indian community in Guatemala. I soon realised that not only was I ignorant, but misdirected.

The main issues there were not medical care, but primary and public health; the lack of clean water or adequate sanitation, no immunisation programmes or contraception and inadequate nutrition. I decided to train in family medicine and public health and went to Seattle to join a new programme called WAMI, which hoped to address the problems of under-served rural populations in the vast rural areas of the northwestern United States.

The WAMI programme

In 1971 four major states in the Pacific Northwest — Washington, Alaska, Montana and Idaho — decided to join forces and tackle the rural health crisis together. They formed the first, and to date the only, regional medical school in the United States — WAMI. The main problems WAMI wanted to address were the geographic maldistribution of physicians, who tended to settle in urban areas, and speciality maldistribution, where physicians tended to enter specialities. So many doctors became specialists that general practice was on the point of extinction.

There were no resources to build new medical schools, but each of the four states had long-standing universities, originally established as agricultural schools. Over the years these schools had expanded to include many of the sciences basic to medicine. That proved to be the key to the new programme because it allowed collaboration to start immediately. It made use of existing facilities and created a situation where there were no losers.

The University of Washington expanded its traditional mission to encompass community-based education and family medicine and the state colleges expanded their mission to include medical education. The programme structure is simple. Each state buys a fixed number of student slots in the WAMI programme. The states then select students from their own residents and these students spend the first year of medical school absorbing the basic science curriculum at their home university. This allows states to give preference to students with rural backgrounds and avoids physical and cultural dislocation that happens when rural students study far from home.

WAMI Department of Family Medicine

The major change in the clinical programme was the shift from specialist training to the training of family physicians. To do that we had to teach our faculty what we all know and that is that the family physician is the backbone of rural practice and any educational programme not based on this basic truth will fail.

With this as the premise, the WAMI programme created the Department of Family Medicine. In addition to training family physicians, we decided to base virtually all our training in the community, with an emphasis on rural and under-served areas. We started a systematic process of identifying the best rural teaching settings, beguiling local doctors to participate, creating relevant curricula for students and learners, launching and supporting the programme. One result of our research was the creation of the Community Health Services Development Programme, which offers these services to all rural communities in our region.

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The Department of Family Medicine now has clinical offerings in every one of the four medical school years and most students are involved in one or more of these experiences.

The University Phase and the Community Phase of WAMI represent the foundation of the programme, but there were other problems to address. One of the most important was the fact that the system in rural areas was neither stable nor rational. We set up a systematic programme of community outreach involving community assessment through interviews and surveys, strategic planning with community leadership and promulgating and implanting a response to the problems discovered.

In addition to the standard curriculum, we also have multiple rural elective experiences for students. For example, first year students spend the summer with rural doctors and immerse themselves in the profession of rural medicine. Over half the class participates and this has a significant effect on their subsequent career choices.

A critical piece of the puzzle is the family medicine residency network — three-year, post-graduate, speciality programmes in family medicine. We now have 18 of these programmes in the WAMI states, with 269 residents in training — the largest post-graduate training programme at the university.

I am currently responsible for the WAMI Rural Health Research Centre. The basic purpose is to perform rigorous, policy-relevant research to assist government agencies to formulate rational and effective policy. We have published nearly 100 articles over the years in these areas and work with state, federal and local governments.

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Summary

In summary, for us the key to solving the health care puzzle is to have a university which is community-based and regionalised. It needs to do three things well: education, research and community outreach. Only in this way can we address the complexities of health care in a diverse and challenging area.

WAMI has been a success and continues to thrive. Last year, at their request, we added the state of Wyoming to the programme, which means that we now cover over one quarter of the land mass of the United States. The programme works here, but needs to be adapted if it is to work in other countries.

I feel that the basic principles underlying WAMI apply equally to every part of the world and can be implemented with reasonable modifications. The key is presenting medical schools whose mission is to address the needs of the communities they serve, rather than merely emphasise the training of future practitioners.

If you start with a mission grounded in service, every aspect of the school is transformed by the desire to make an impact in the real world. If you hold the schools and post-graduate programmes accountable to attaining those goals, you will get their undivided attention.

Conclusion

Our world is at once giant and tiny. The human community is divided by race, culture and language and united by biology, environment and a common destiny. The glory of conferences such as this is that they bring creative and restless practitioners together from around the world to confront common problems. Family doctors have an opportunity to shape the future of rural medicine on a global basis and conferences such as this are a wonderful beginning. The next step is to work together on our home turf, increase the intensity and frequency of exchanges and continue to share our best ideas and most noble aspirations. ●