

National Rural Health Alliance E-forum - 3 September 1999

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NRHA/AHA STATEMENT ON FRINGE BENEFITS TAX CHANGES

A joint statement by the Alliance and the Australian Healthcare Association on the Government's fringe benefits tax proposals was issued on 24 August 1999. The statement is available at <http://www.ruralhealth.org.au/24899.htm>.

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From: Mark Dunn <markdunn@pop.hbt.tassie.net.au>
Subject: Pharmacy Legislation Review

The Productivity Commission's submission to the review of pharmacy legislation also said:

"The commission's submission admits that its proposals may result in reduced numbers of pharmacies in suburbs and country towns but suggests that a decline would happen in any case."

a pessimistic and erroneous view. The productivity commission represent the peak of the micro-economic reform and market economy sides of the debate. A nasty bunch indeed. They go on:

".....deregulation could prevent the closure of pharmacies in rural areas."

because

".... scope to offer pharmacy services within supermarket and other general retail outlets could reduce the minimum population required to support a pharmacy service,"

Not true, as a pharmacist would always still be needed in the pharmacy and this is far and away the largest cost associated with a pharmacy operation.

Senator Ron Boswell's comments in response appeal more to me. "I understand competition and I understand the need for it," Senator Boswell said. "But we need

a strong independent business sector to prop up the smaller country towns."

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From: Council of Remote Area Nurses of Australia <crana@ozemail.com.au>
Subject: 17th National Annual Council of Remote Area of Australia Conference

Just to let everyone know that the 17th National Annual Council of Remote Area Nurses of Australia Conference is on again this year in Melbourne. Yes the bush comes to the big smoke. This year's theme is 'Facing the Challenge of Change' with four major themes covering the four full days of the conference, they are:

- * Support, Education and Training
- * Clinical Practice
- * Legal and Professional and
- * States and Territories

The five keynote speakers include John Lawrence, Chair NRHA, Ms Mary Murnane, Deputy Secretary Commonwealth Dept. of Health and Aged Care, Mr John Kelly, President Royal College of Nursing, Australia, Chris Sidoti, Chair Human Rights and Equal Opportunity Commission and Ralph McLean, Deputy Director, Rural Health Victoria.

Full registration details can be obtained from our website on <http://www.crana.org.au>. We would especially welcome the undergraduate fraternity in Victoria to attend (special student rate of \$250.00 for the 4 days) and of course the nursing profession in metropolitan Melbourne.

The venue is the 'Bayview on the Park' 12th (3-6pm registration with the Minister for Health Victoria opening the conference at 7pm) to the 16th of September. Please direct all enquiries to Wilma Johnson or Nigel Jefford at the national secretariat in Alice Springs.

Look forward to seeing you there.

Regards
Nigel Jefford
Director
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CRANA was formed in 1983 with the main aim being to promote the delivery of safe, high quality health care to remote areas of Australia.

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From: Richard Sager <richard.sager@studentmail.newcastle.edu.au>
Subject: 4th National Undergraduate Rural Health Conference

The 4th National Undergraduate Rural Health Conference to be held at Wagga-Wagga 15th -19th September has at last a program that is now published on the web at <http://www.ruralhealth.org.au/nrhn/program.htm>. Please note amendments may be made before leading up to the conference.

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From: David Cameron <s001083@student.uq.edu.au>
Subject: Student rep on RACGP Rural Faculty

Hi there from Queensland, you know the place where it's raining today, pouring the next! And some clever marketing guru had the clevers to name parts of it " The Gold Coast" and "The Sunshine Coast"!!

Just introducing myself as the student rep on the RACGP's Rural Faculty.

I'm in my 3rd yr of the Uni of Qld Graduate Medical Course. I'm in the guinea pig bunch who started in 97. This year we have escaped from the med school full time to do rotations in Med, Rural, Surgery, Mental Health & GP. Next year we do Obs & Gyny, Paeds, Medical & Surgical Specialities before a BIG!! (=scary) all-encompassing exam week about the time of the Olympics. My first degree was a B Ag Sc from Adelaide Uni. I've been a high school teacher for 17 years, starting at Hope Vale & Bowen, NQ, Melbourne, Hermannsburg, NT and lastly 7 years in Toowoomba.

I have been the 1st and then 2nd yr rep on TROHPIQ. Now I'm the student rep on the Rural Faculty of the RACGP. Mostly that means listening in and reporting to monthly teleconferences Over the 18th to 20th June weekend the Rural Faculty held a face to face meeting in Sydney to discuss many things.

Recent concerns of the Rural Faculty have been -

- relations with ACRRM - who should oversee rural training plans and assessment
 - who should represent rural health workers
- possible development of a Dip Anaesthetics similar to the Dip Obs for rural trainees
- coping with the national president of the RACGP's statement that
 - "there is no diff between city & rural practice"
- matters from the Fed Budget - bonded scholarships.

Any students with sparks of brilliance, questions to clarify or relevant concerns please contact me via the e-mail at s001083@student.uq.edu.au or m.c.cameron@usa.net.

See you in the bush somewhere,
David Cameron

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RHEF SATELLITE BROADCASTS

The next Rural Health Education Foundation satellite broadcast is scheduled for 28 September on stroke prevention. Further details are at <http://www.rhef.com.au/timetble/Stro/Stro.htm>. The satellite broadcast timetable is at <http://www.rhef.com.au/timetble/timetble.htm>, while details of viewing sites are at <http://www.rhef.com.au/satsites/satsites.htm>

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ABS PHYSIOTHERAPY SURVEY

Only 24% of Australia's physiotherapy services are located outside the capital cities, according to an ABS survey of physiotherapy services. The main features of the survey are available at <http://www.abs.gov.au/websitedbs/D3110122.NSF/66b4effdf36063e24a25648300177cd5/f8b3beb1b207eeb3ca2567de000531cb?OpenDocument>

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TECHNOLOGY AS A COMPLEMENT TO TRADITIONAL MEDICAL TRAINING Kay Stevens, Royal Australian College of General Practitioners, <http://www.racgp.org.au>

[The following article is reprinted from ONLINE-ED of 30 August 1999. See <http://www.edfac.unimelb.edu.au/online-ed/>]

VOCATIONAL MEDICAL TRAINING appears slow to adopt the benefits of online education. Universities and other higher education institutions now commonly thrust undergraduate students into online teaching and learning environments. However, postgraduate students in vocational medical training have a more limited experience of online education. In the training program of the Royal Australian College of General Practitioners (RACGP) an apprenticeship model, together with oral Socratic traditions of teaching and learning, impede the motivation to use online education. Money and resources are less of an impediment.

IN GENERAL PRACTITIONER VOCATIONAL TRAINING, online education conflicts with accepted teaching and learning styles. Conceptually, online education represents a form of distance education which uses hypermedia for its delivery. Online education fosters a democratic exploration of knowledge and learner-centred teaching styles. As such, online education confronts the privilege of oral traditions and the master/apprenticeship models of knowledge ownership and knowledge dissemination.

IN THE VOCATIONAL TRAINING PROGRAM of the RACGP, affirmative action programs are currently being undertaken to provide many Australian GP registrars with access to the Internet. This has been achieved through an increased provision of computers and establishment of ISP connections for many GP registrars situated in rural and remote areas. This increase in Internet access is identified in the RACGP Training Program as a way to increase educational and peer interaction and so improve the quality of being a registrar in an isolated area. Currently, an evaluation of this increased Internet provision is being conducted from within the RACGP to identify the level and success of its principal objective; namely, to reduce registrar isolation.

THE REDUCTION OF ISOLATION in an educational context is a worthy objective. It relates to the social well-being of a GP registrar as a learner. It affirms what all educational sociologists acknowledge; namely, that to improve the social well-being of learners generally improves their motivation to learn. However, this objective to improve the social well-being of GP registrars does not address more specific problems relating to teaching and learning online. It does not address the conflict in teaching and learning styles that occurs between the more learner-centred and democratic possibilities of online education and traditional medical training approaches. Rather, any challenges to oral traditions of vocational medical training incur 'group think' responses which appear to place greater value on elitist credentialism than presenting clear educational reasons and directions for the successful implementation and maintaining of online education. In particular, the objective to improve the social well-being of GP registrars does not focus on the activity of learning.

MOST VOCATIONAL MEDICAL TRAINING is based on an oral tradition of teaching and learning. Technology plays a very small role in the oral teaching and learning style of vocational medical training. Nor is technology identified as strongly contributing to the master/apprentice teaching and learning model of vocational medical training. Rather, in professional medical practice, technology best serves science and business constructs. Technology is used in medical clinical practice with great expertise. Additionally, technology is used in medical practice management applications with increasing confidence. However, in professional vocational medical training - and this area of professional training is distinct from those medical undergraduate education programs where learning occurs on the virtual patient - technology is often only used in behaviourist programs of the Computer Aided Instruction type to increase professional knowledge. The more democratic and humanist online education models, which support exploratory and student-centred approaches, are generally avoided.

THE ORAL LEARNING STYLE of traditional vocational medical training is not a good basis for democratic and humanist educational approaches. An oral tradition of medical training places emphasis on verbal skills and auditory memory. It uses scientific models of deductive reasoning to challenge positivist analyses of medical practice. Alternatively, online education reinforces the egalitarianism of print as something accessible and retrievable. Online education places emphasis on written communication skills and inquisitive searches for ideas.

ONLINE EDUCATION GENERALLY ADOPTS A SOCIAL SCIENCE MODEL OF LEARNING. It aims to

heighten student consciousness by encouraging an ability to identify and critically reflect upon knowledge relationships and by encouraging personal opinions. These are facilitated through the manipulation, exploration and reconstruction of text and ideas. In particular, the deconstruction and reconstruction of knowledge that can occur with hypermedia and hypertext totally belies the constructivism of traditional curricula of vocational medical training; in particular as these curricula were, until recently, mainly transmitted orally. Written curricula are a current phenomenon.

IN ASSESSMENT TERMS, traditional vocational medical training curricula relate only to the objectives of a summative examination. Ongoing assessment - referred to as 'in-training assessment' - is yet to be introduced to general practitioner vocational training. Accordingly, online education with its conceptual basis in distance education, and its emphasis on text and ongoing written assessment activities, conflicts with the oral teaching style of vocational medical training.

ONLINE EDUCATION ALSO CONFLICTS with the hegemony of an oral information system and a master/apprentice relationship to training. Students who learn in an oral mode are subject to the disempowering vagaries of the spoken word that is reinforced in the power relationship of master and apprentice. Oral systems of information are seen to encourage such hegemonic learning relationships: information is not inseparable from the position of privilege and authority of the author. The descriptions of Tom O'Regan of the oral systems used by Warlpiri aboriginal people make this point
<http://kali.murdoch.edu.au/continuum/3.2/EMWork.html>

THIS ORAL TRADITION OF GENERAL PRACTITIONER VOCATIONAL TRAINING that GP supervisors and medical educators maintain, is really quite recent a one. Its heritage is short. Although general practitioner vocational training has a twenty-six year history, compulsory vocational training for government registration has only existed for four years in Australia. This conscious adoption by general practitioner vocational training for the teaching style of an oral and apprentice tradition can be seen to constitute a strategic response for establishing, through a comparable level of credentialism, another area of medical specialist practice.

WHILST THIS SEARCH FOR TRADITIONS by general practitioner vocational medical training does provide some stable foundations, they are foundations that affirm traditional forms and consciousness of educational control and interaction. Oral traditions do not affirm democratic or learner-centred values.

THE HOPE OF TECHNOLOGY is to support the democratisation of vocational medical training. The new generation of general practitioner training is not totally mesmerised by traditional norms of credibility. In particular, the curriculum of the RACGP training program now has less emphasis on skills-acquisition than have many other medical specialist areas of vocational training. The RACGP training program curriculum identifies cognitive domains that place greater emphasis on conveying, observing and critiquing medical professional practice. In particular, the emphasis is on interpersonal skills and communication. Professional skills acquisition, and the consequent need to merely convey, retrieve and manipulate objective information, is being reduced.

THE PRINCIPAL HOPE is that democratic and humanist educational goals for vocational

medical training will be strengthened as vocational medical curricula move towards exploratory and learner-centred methods. Already, principles of learner-centred education are seen to reflect the humanist and democratic goals of patient-centred medical practice now being encouraged in the curricula. These goals will be complemented by online education. In turn, online education will be more readily accepted and relied upon for curriculum implementation.

THE FURTHER HOPE is that the motivation for greater online education in vocational medical training will come from the patient community itself. This is a move to a socially constructed consciousness of medical practice. Social constructivism, as Vytogsky identified it, generates meaning for practice and education through a consciousness of the community to which it relates:

<http://www.coe.uh.edu/~srmehall/theory/social.html> Socially constructed medicine extends the concept of medical training beyond that of a humanist (and possibly paternalistic) concept of patient-centred medicine.

AS THE PATIENT COMMUNITY NOW GAINS GREATER ACCESS TO THE INTERNET, a need for more

critical and reflective medical practitioners is reinforced. The patient community now has recourse to information that can challenge established medical views and their interests will thus motivate general practitioner registrars to use online education for democratic and exploratory learning for the purpose of social, as well as scientific, critical consciousness.

THE MOTIVATION FOR THE USE OF EDUCATIONAL TECHNOLOGY in general practitioner vocational

medical training, particularly online education, is not yet strongly established. For the purpose of reducing the isolation of rural and remote GP registrars, online technology is made available to increase learner well-being. However, this motivation from within medical training does not address the need for online education to assist with the practice of teaching and learning. To achieve this, the best motivation may come from without. It may well come from patients themselves.

Kay Stevens
RACGP

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CONTRIBUTION AND SUBSCRIPTION INFORMATION AND DISCLAIMER

The NRHA e-forum is a forum for the expression of YOUR views. Contributions are sought on any topic relevant to rural health concerns. Please send contributions to the moderator, Jim Groves, at grovesc@winshop.com.au.

The NRHA e-forum is edited by a third party moderator, Jim Groves. As such, the Alliance does not control postings and the contents do not necessarily reflect the opinions of the Alliance or Jim Groves. Jim Groves can be contacted at grovesc@winshop.com.au.

The e-forum is sent to a mailing list of the Alliance and those have indicated interest through the subscription box at the NRHA Web site (<http://www.ruralhealth.org.au>). This

issue is going to 615 recipients. Please forward a copy to any colleague you think may be interested.

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