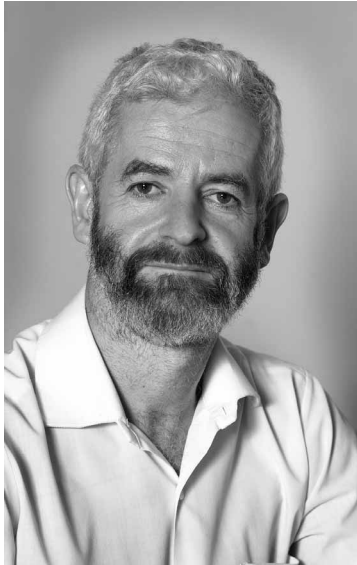


MAKING A DIFFERENCE

An Interview of Ian Wronski



Dr. Ian Wronski is Executive Dean of the Faculty of Health, Life and Molecular Sciences at James Cook University in Townsville, Australia. I interviewed him in October, 2003 in Townsville during the Post Conference Meeting of The Network: TUFH. We continued our conversation by email. The following is an edited, abridged summary of our conversations.

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How did you get involved in medicine?

Medicine was just one of the things I was always interested in. When I went to medical school, there was no clinical integration in the first 2 years, so you didn't find out if you liked it until a long time into the program. When I finally did do clinical work, it was fantastic. I was sure I was in the right place.

It's a wonderful vocation that's allowed me to have four or five careers. Early on I was interested in indigenous health, medical education, and health force issues. Later on I had the opportunity to bring these interests together.

I understand that your involvement in indigenous health began while you were still in medical school.

I was curious. Some people put it down to a Jewish tradition with Eastern European origins. I guess that's true. As a student I was involved, on the edges, in the early establishment of Aboriginal Health Services in which the community participated in decisions about their own health needs. This was in the 1970s during a worldwide period of deep soul searching and adventurous thinking.

At Monash University I was involved in a medical student strike. In about 1974 I was President of the Medical School Society. We were trying to force changes in medical education. This was a critical turning point in the progressive development of medical education.

What were you students asking for?

At the macro level, we felt that medicine wasn't oriented enough to meeting health needs in the Australian population. For instance, we recognized that patient care was moving away from teaching hospitals into the community and that a population health focus was becoming increasingly important. However, almost all our clinical experiences were in big urban hospitals.

Naturally a course issue was the precipitating factor for the strike. Those of us who had just completed a couple of years of clinical education were to be examined separately on our earlier preclinical work. This issue struck a chord with almost everyone because it was a microcosm of the much deeper issue of the disconnect between medical education and the real world.

Monash University began a significant period of educational developments, which were followed by changes at Flinders University and then changes at the University of Newcastle. Now JCU [James Cook University] has developed a new and innovative curriculum, so the baton has been passed for about 30 years.

What did you do when you completed your education?

I surprised myself by going on to Broome [a remote, sparsely populated coastal town in the Kimberly region of NW Australia]. I had been working in an infectious disease hospital and probably planned to be an infectious disease physician or something like that. One day one of the early founders of the Aboriginal Medical Service movement in Australia rang up and said, "They're trying to establish an Aboriginal Medical Service in Kimberly Australia. Would you be interested in helping them do it?" I hadn't contemplated that, but, before I knew it, I said, "Yes".

I agreed to work in Broome for 3 months. Some 14 years later, I was still there. The Broome Regional Aboriginal Medical Service where I worked was one of the first AMSs [community-controlled Aboriginal Medical Services] in the country. During its first years, the government refused to fund it, so Aboriginal people volunteered their labor. I was funded through fee-for-service arrangements. It wasn't a great salary but it was exciting stuff.

It wasn't until 1982 that the breakthrough came. The federal government began direct funding of a number of AMSs, including the one in Broome. Now there are about 127 AMSs. They are the dominant moral authority in terms of Aboriginal health in the country. AMSs also provide the leadership in thinking about and delivering effective health services.

As this organization grew, I wasn't pleasing anyone. With a huge clinical load and hospital and administrative responsibilities, I sometimes wasn't there

when women who I was caring for came into labor. On the other hand administrative people would get mad when I couldn't make it to a meeting. So in the mid 1980s, I greatly reduced my clinical load and began a new career in which I focused on population health.

What was your position?

I was Director of Health Services for the newly established Kimberly Aboriginal Medical Services Council. Soon after Broome set up an AMS, people in East Kimberly wanted an AMS. Then other more remote communities in the region wanted one. The communities saw the advantages of working together and sharing resources, so in 1986 they created the Kimberly AMS Council.

When I became director, I was short on skills. I was awarded a scholarship and studied at Harvard for a while.

What did you study?

Health policy, management, and epidemiology. I did a couple of masters' degrees and developed some networks. I then came back with these tools, which came in very handy in my new career.

Wasn't it during the mid 1980s that you developed some important HIV/AIDS programs?

I was involved in initiating the first intervention program on HIV/AIDS for remote Aboriginal communities. We collaborated with traditional Aboriginal leaders in re-orienting certain traditional practices in order to safeguard against the spread of AIDS. This has had a significant and lasting impact in a number of traditional communities.

We had a successful nationwide campaign promoting the use of condoms in rural communities. This was at a time when the popular belief in health circles was that such a campaign would not work.

Working with Aboriginal community elders, several communities, linguists, and the Health Department of Western Australia, I helped with the production of the first educational videos on AIDS in Aboriginal languages.

I was also involved in co-initiating and co-founding a Kimberley-wide Aboriginal community controlled health decision-making structure. It was the first of its kind in Australia. This structure was a type of "health parliament" that administered, planned, and developed clinical and public health services over vast areas among an extremely heterogeneous group of communities.

By the early 1990s, our kids were getting to the age where we were worried about their education. There was no sign that rural education was getting any better, so we were worried that they weren't going to get a fair go.

About the same time, out of the blue, JCU asked me to direct the Anton Breinl Centre for Tropical Health and Medicine. The institute, formerly called Australian Institute of Tropical Medicine, was the first medical

research centre of its kind in Australia. It had been moved to Sydney. Now it was back at JCU in Townsville. It was struggling and needed direction. I agreed to give it a try.

What was the mission of the Centre?

Its mission was to research diseases relevant to North Queensland and its tropical neighbors. I thought that mission was too narrow, but I was given a pretty broad hand. In 1993, we helped turn the focus to population health by establishing the Department of Public Health and Tropical Medicine. Our main interests were Aboriginal, rural, and tropical issues. We extended our area of interest to include Papua New Guinea and the West Pacific.

The Harvard people helped a great deal as we established mostly postgraduate programs. In 2 or 3 years, the number of postgraduate students grew from 17 to 260. Most of them were Australians. About 40 were indigenous students.

That's wonderful.

The indigenous community in Townsville warmly welcomed my family and me and took us under their wing. Later I found out that they had helped persuade the university that my appointment was a good idea.

So they were significant in your coming.

I think so.

What kind of programs did you develop?

We established a public health, tropical medicine training stream – from the diploma level through the masters and PhD. We focused on developing a relevant rural and indigenous workforce. My interest in developing such a workforce went back to my Kimberly period. In 1983 we established one of the first – and probably one of the most viable – Aboriginal health worker training programs. We began to produce our own indigenous worker health force.

So you were able to build on your earlier efforts. Then what happened?

In the mid 1990s, the funding mechanisms for Australian universities changed. The old structures were thrown in the air, and there were opportunities to create new structures. Our senior consultants recommended that we expand our work in public health and tropical medicine and increase our health offerings in the university. I was asked to become the first executive dean of that new grouping.

We pulled together and ensured the successful accreditation of six programs: occupational therapy, medical laboratory science, nursing post-graduate specializations, the indigenous health worker program, pharmacy, and medicine. We also began building a new faculty of health and bioscience by

helping the existing basic and biosciences develop a shared vision that included new opportunities to form links with the health professions programs.

What were some of the challenges you and your colleagues faced?

For 25 years there had been no new medical school in Australia. The government reports were still saying that we didn't have a medical work force shortage, despite the fact that we had had a shortage for at least a decade, particularly in rural, indigenous, and tropical areas.

We had to jump a number of hurdles in order to establish the medical school. We had to have a new hospital facility. The State Government had to match 10 million dollars for capital provided by the Federal Government. Also, we had to be accredited by the Australian Medical Council.

Bit by bit we knocked off these hurdles and the political opposition. This was thanks to the mobilization of a huge coalition of community organizations, professional bodies, regional development bodies, and governmental organizations and politicians at all levels.

Now that we have a new medical school, the Australian National University in Canberra will start a school next year, and there will probably be other new schools in 4 or 5 years.

What are some of the features of your health professions educational program?

Indigenous, tropical and rural health are throughout the whole curriculum. We do that in different ways in different professional areas.

We kept our sciences – biomedicine, molecular sciences, and even chemistry – so we don't have to go outside of our organization to get scientists to teach. This gives us more flexibility and options than most medical school have.

We're interested in the PBL concept but decided not to use the format of building the curriculum around 35 or 36 problems. We have to prepare doctors who can work independently in rural areas and be familiar with a wide range of conditions, so we have to be sure that nothing falls between the cracks. For us a systematic approach tends to have better coverage.

What do you mean by systematic?

In teaching the GI tract and other areas, we use many strategies in addition to the presenting problem of a patient. At the end of each week we look at the course material in relation to practical clinical cases. In another session, issues covered in four subjects are drawn together in a case. For instance, human biology, cellular communication and human health behavior and rural health services are examined in all their complexity in a session called "Young and Pregnant in a Small Town".

Our curriculum is vertically and horizontally integrated. Clinicians are present from day 1, and, starting in week 2, our students get clinical exposure. I think we've been able to capture a lot of the attractive features that the PBL

revolution brought, but modified it enough to deal with the needs of our graduates.

We also went for a 6-year undergraduate program. In order to deal with rural, indigenous, and tropical issues, we want our students to have that extra year – almost a pre-internship – to shape their skills in ways that aren't possible in a 4- or 5-year program.

What will they do?

Students can spend their last 2 years outside of Townsville in towns where JCU has partnerships with local medical and educational centers. Lack of certainty about their skills scares some people away from taking a remote position. We hope that our students' additional clinical experiences will make them more confident about doing remote rural practice.

We knew it could be a disadvantage to have the longest program in Australia, but we're getting about 1200 applicants each year for 60 positions. (There will be 100 positions next year.) There's no sign of interest declining.

You have been drawing indigenous people into your health professions educational programs and are eager to bring in even more. What strategies have you been using?

At JCU 600 of the 8000 full-time equivalent students are indigenous. Ninety of these indigenous students are in our medicine, nursing and other health professions programs. That's easily the largest number of indigenous people in medical and other health professions schools in Australia. And the numbers are increasing.

There are 30 indigenous staff at JCU. About a third are in our Faculty. That number may seem small, but it is substantial in the current Australian scene.

I don't think we're yet identifying people when they're young enough. I think we should consider health camps and mentoring, like they do in South Dakota [in the USA]. We're trying different things in the various professions because the personalities of people going into the various professions are slightly different.

We're not self-satisfied but we think we're on the right set of rails. We can see the numbers building. So we're optimistic.

Many of our staff members – both white and Aboriginal – have worked for long periods of time with indigenous communities. Through these people we have had access to communities. This has made it easier to draw indigenous staff and students to JCU. The staff members with connections to Aboriginal communities have also helped to create a political base, which has helped us make the case that the education of indigenous health professionals is important.

Some indigenous communities have agitated politically for us to work with them. For example, as a way to make nursing education more accessible to indigenous and rural people, we have offered our Nursing Sciences Program

not only on our Townsville campus, but also in Cairns and Mount Isa. The Torres Strait Island people also wanted a program that would be accessible to their people, so they leaned on their government. Now the Nursing Sciences Program is offered on Thursday Island in the Torres Strait.

You seem to be reaching out well beyond the earlier boundaries of JCU for partnerships with others.

We have created what we call the Tropical Triangle. It's a group of health and medical institutions that includes the Fiji School of Medicine, the University of Papua New Guinea and JCU. We are promoting collaborative approaches to research and education in tropical and community medicine.

I think there's a huge amount to gain from international discussions, exchanges, and other activities. That's why we were so excited to host the Post Conference of the Network: TUFH and, before that, the First International Indigenous Health Conference at which we had indigenous representatives from Canada, the USA, New Zealand and Australia. People from the outside can shed light on areas that are difficult to discuss within a national construct. Although you always need local solutions, many of the general principles are the same.

That's true. We'll be eager to learn how you and your colleagues progress with your many innovative initiatives. Thanks.