



# Rural CME in Iraq: SRPC Care to Care Project — 2003

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On November 2nd, 2003, the authors, members of the Educational Committee and Rural Critical Care Course of the Society of Rural Physicians of Canada (SRPC), and one spouse left for northern Iraq (Iraqi Kurdistan) to assess the feasibility of delivering continuing medical education (CME) to rural physicians in a beleaguered and underserved area of the world. Four months of negotiation and networking with a multitude of non-government organizations made it clear that rural continuing medical education was a novel approach to capacity-building in health care for many of these agencies. Eventually our team networked with the organization Helping Hands through an SRPC RuralMed contact, Dr. Lance DeFoa, a physician in northern Ontario. Helping Hands provides transportation and medical and political contacts within northern Iraq.

**W**hile Iraq hostilities remained prominent in the news, hostilities had largely settled in the Northern region by the time we arrived. From the gassing of the Kurds in 1988 through the embargoes of the '90s, this area has remained under-resourced and irregularly serviced.

### SETTING GOALS

Before arriving in Iraq we listed the following goals:

1. to safely assess the feasibility of delivering CME and faculty development to rural Kurdish physicians;
2. to understand their educational, and personal needs and experiences;
3. to understand the medical system and politics, and the role of primary and rural health care;
4. to explore the development of long-term projects in view of the above; and
5. to listen to where people are at in the peace/conflict/ healing process.

### IRAQI MEDICAL ADMINISTRATION

It was important for the team to recognize several political and administrative realities. Kurdistan's eastern province of Sulaimanya was inhabited by the Talibani tribe, whose political affiliation was with the Patriotic Union of Kurdistan while the western province of Irbil was largely of Barzani heritage and politically aligned with the Kurdistan Democratic Party. The program therefore included meetings with the Minister of Health of each province and their respective deans of medicine.

Through our first series of meetings, we further learned that the Regional Ministries of Health were responsible for the rural hospitals, and the university was responsible for the 3 Northern medical colleges and their urban teaching hospitals. The ministries of health were keen to see our team teach in the rural districts, and the deans encouraged our presence in the medical schools and urban centres. Some time was therefore spent in each setting, but most teaching focussed on rural areas. The idea of teaching in the rural hospi-

tals was completely foreign to the medical deans, so our team felt this was an excellent opportunity to model rural CME. It became apparent that CME was unusual in the urban teaching centres as well, and appeared to generate a great deal of interest. Consequently, several 2-hour lectures were given in the city centres to groups of 80–100 participants, before moving out to the countryside.

The Iraqi medical system includes mandated rural service. After completing 6 years of medical college following high school, all candidates do a 1- or 2-year rotating internship with 1 month of rural placement. Following that, they are considered general practitioners, and are assigned to a rural centre for 2 years. Since this is mandated, many physicians are in a holding pattern to return to the city centres and specialty training for another 2 to 4 years. The universities do not yet recognize general or family practice as a self-standing discipline, but admit this is an area for future development.

In Kurdistan, there are 3 medical colleges within 2 provinces with a combined virtual name of Saladin University. In fact, the province of Irbil has

medical schools in the cities of Irbil and Duhok, and the province of Sulaimanya has a medical school in its regional city of the same name. Each medical school has 600–700 medical students spread out over their 6 years of training.

## UPON ARRIVAL

After flights through Germany and Turkey, we took a taxi across eastern Turkey and the complex Turkey–Iraq border. Shared fears of safety fortunately settled after a successful crossing, and the meeting of members of our hosting agency on Iraqi soil.

Our team met with the Irbil regional Minister of Health, an oncologist, who placed a high value on CME and noted that the timing was ripe because the medical supply and electrical situation had recently stabilized following the chaos in the aftermath of the overthrow of the central government. He paved the way with the regional health director and the hospital director in Soran, located 2 hours away through the mountains. Soran was our first planned rural teaching community with 10 000 people and a catchment area of 60 000.

## SORAN

The Soran medical staff included 12 specialists and 25 GPs. Sessions were held in this Islamic area during Ramadan, when most of the medical staff was fasting from sun-up to sunset. Consequently, concurrent 1-hour sessions were run at 11:30, with longer 2-hour sessions at 18:30 following the evening meal.

The 3 educators brought prepared topics gleaned from the SRPC Rural Critical Care Course, Problem Based Small Group Learning, Scientific Assem-



Bill Curry

Teaching team, in Soran. L to R: Karl Stobbe, Dale Dewar, Len Kelly



Len Kelly

Dale Dewar, teaching a small group session in Soran.



Len Kelly

Emergency department, in Soran

bly presentations, and resident and student training workshops.

The topics presented were:

Canada: "Our home and native land"

C-spine management and x-ray interpretation

Upper limb orthopedics

Hand and tendon injuries

EKG interpretation

Asthma management

Joint injections

Hypertension management

Emergency cases management

Fertility/infertility and contraception

Dysfunctional uterine bleeding

Knee exam

CVA management

Burn management

Post-partum haemorrhage

Over 4 days of the first week, the 14 hours of CME were each attended by 20 to 30 physicians, who completed evaluations designed specifically for this setting. Evaluations focused typically on content and teaching but also included feedback on pace of lecture, use of language, timing and suggested improvements and topics. After each session the evaluations (totalling 165 at this site) were read, and

hallway discussions led to a constantly changing curriculum. Teaching modules were customized to meet the needs of the participants on a daily basis, and new modules created. The Kurdish physicians were a keen and bright group who enjoyed lively exchanges in English, the medical language of Iraq.

We slept in vacant patient rooms in this rural hospital and ate and socialized each day with the physicians. This led to the development of a close teacher/learner/colleague rapport. Interestingly, this presented an educational challenge, as the feedback was immediate and called for modifying teaching styles (small groups, hands-on workshops, case-based learning, learner participation in x-ray interpretation and didactic sessions). In addition to teaching there were visits to satellite clinics, work in the emergency department and operating rooms, and attendance at hospital rounds.

## HALABJA

The second week, our team moved to the second northern province, Sulaimanya and its capital city of the same name. Following lectures in the city itself, we travelled a bumpy 2 hours toward the mountains and the Iranian border community of Halabja.

Halabja is infamous for being the location of a chemical weapons attack by the Iraqi central government in 1988. For a 3-day period beginning March 16th 1988, the community was exposed to 45 aerial bombardments, including multiple unknown nerve gases; 5000 of the 25 000 local inhabitants died immediately and the rest fled to other regions of Iraq and through the mountains into Iran. Some 15 years later, the ground water and soil have yet to be tested for residual safety. The medical staff reported high prevalence of respiratory, neurologic, oncologic and fertility sequelae in



Local shepherd in Mosul



The muddy drive to Halabja



Child and grandmother in Halabja



patients. The extent of weapons of mass destruction deployment in Kurdistan is only now being uncovered, with the likelihood that over 250 rural Kurdish villages were targeted in the late '80s.

The local hospital director of Halabja and his medical staff of 12, most of whom were general practitioners, met with us for a series of interactive workshops over another 4 days. Being close to the Iranian border, the community was not felt to be safe enough for westerners, so at the Ministry of Health's suggestion we spent 4 hours a day travelling by road to and from a more secure area.

An afternoon was spent at the Halabja museum, which documented the atrocities of the nerve gas attack. The SRPC members met with some of the nerve gas survivors, and were invited to return in the future. Unfortunately, in such a remote site in an underdeveloped medical system, little more than supportive care could be rendered for the still unknown effects of chemical weapons exposure. Since the April 2003 overthrow of the central Iraqi government, this community felt they were finally free of the daily threat of renewed aerial attacks.

## PROJECT EVALUATION

Throughout the visit to Kurdistan, our team met dozens of rural physicians and learned of the lack of resources they encounter. (For example, surgeries had been cancelled recently for lack of gauze.) We met with 2 regional ministers of health and 2 medical school deans. Lectures occurred in several large urban settings, however most of the time was spent in small workshop settings in 2 rural areas. In total, 34 hours of CME were delivered. The 3 educators spent an additional 30 hours developing new education modules and re-tooling prepared ones for delivery in response to local requests and feedback received. All lectures and workshops were evaluated with a written evaluation form (395 in total), designed specifically for the setting. The evaluations were strongly supportive: that CME was highly valued, particularly in remote regions, which are left out of the existing medical education network. At the final session in each rural community, a CD-ROM containing photos from the area, lecture slides of the presentations and requested patient handout information were left with the hospital administrator and his staff. We were welcomed and cheerfully engaged by everyone with whom we were in contact.

We felt we were able to address most of our goals. Not only did we get a sense of the CME needs, we were able to deliver a multitude of educa-

tional sessions. We saw that faculty development remained a future challenge to address as the culture of CME becomes increasingly established. We met many colleagues and developed friendships beyond our expectations.

One team member stated that it "*far surpassed expectations with respect to welcome, teaching opportunities, safety and travel opportunities.*" Another noted: "*[I] developed a respect for the skill and knowledge of Kurdish physicians*" and found the people "*fiercely proud, warm and welcoming ... we will never fully understand the decades of suffering and loss they have endured.*"

## FUTURE DIRECTION

Before leaving Iraq, we had several discussions with several non-governmental organizations and discussed melding our involvement with a developing medical education program from the University of East Tennessee, which has a successful model of rural training and recruitment and an intention for some curriculum development with the Kurdistan medical colleges. We discussed our experience with these and related issues (e.g., telehealth initiatives in Canada).

Expectations at the onset were that a needs assessment would be done and that some teaching would occur. The experiences of our team led them to reaffirm that rural CME, as we have discovered in Canada, has a valuable role in supporting rural colleagues and the communities they serve. We encountered a warm reception and met many physicians who were very interested in learning about up-to-date management of common primary and secondary medical care topics. The travel, cultural experiences, language difficulties and bouts of various travel ailments affirmed that cross-cultural medical education presents rewarding challenges.

As a team, we hope that sufficient local and governmental contacts have been established to engender a longer-term project and we hope to invite colleagues in the SRPC to help continue this educational initiative in the future.

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