Difficult legal precedent established for rural surgical competency

The views expressed in this editorial are those of the authors and do not necessarily reflect the position of the Canadian Medical Association or its subsidiaries.

Confirming competency in medicine and surgery has been historically challenging, and evaluating the competency of practising physicians is a crowded minefield. Competency programs from the Royal College of Physicians and Surgeons of Canada and some of the provincial colleges have been suggested and often adopted as a proxy for surgical competency. Certainly, no program can be an exacting evaluative tool for medical knowledge and practice.

External structures exist for examination of medical competency in retrospection. Patients can report concerns to hospital boards or provincial medical associations and regulatory authorities, and their concerns are taken seriously. Bringing medical malpractice lawsuits has been a draconian method for patients to have the competency of physicians judged through the eyes of the court. One such case is that of *Dumesnil* v. *Dr. Jacob* in Manitoba,[1] where the Court of Appeal ordered a new proceeding in a malpractice claim for which a previous trial judge had ruled that the physician — a community-based general surgeon with some orthopedic training — had met the standard of care. The judge had reasoned that the physician was not subject to the same standard of care expected from a specialist orthopedic surgeon, particularly a trauma specialist. The care was delivered in a centre located more than 100 km from Winnipeg, where most of Manitoba's orthopedic traumatologists practise. Interestingly, the Court of Appeal then ruled that there was a need to set the standard of care higher, to that approximating the standard expected of a physician practising in an academic centre. Whether the complication or outcomes the plaintiff experienced would have been different in any other setting, including an academic orthopedic practice, is difficult to ascertain. This case points out that there is either an impending or current crisis in regard to the delivery of surgical care in Canada.

This deficiency is most acute in the rural and remote areas of the country. The previous cohort of aging general surgeons willing to practise a diverse set of skills is shrinking rapidly. Cases like the one described above will be less frequently treated in rural settings in the future. Surgical training in Canada essentially occurs in academic health centres or affiliated urban hospitals where most practitioners are specialists. The Canadian Association of Surgical Chairs highlighted this reality in a *CJS* editorial published in 2002.[2] Rural community hospitals have had surgeons with a broad range of surgical skills that have not been strictly limited along traditional speciality borders. General surgery in rural centres included orthopedic surgery, neurosurgery, gynecology, urology, vascular surgery, thoracic surgery, and otolaryngology.[2] Replacement of rural surgeons, as we go forward, will be more difficult because of this case.

We know there is an urgent need for rural replacements. More specifically, Ma and colleagues explored the needs in a *CJS* article published in 2023.[3] They predicted a need for 370 rural surgeons over the next decade. That number means that, at current demographic values, 43% of general surgery graduates in Canada will need to enter rural practice. A total of 18%–30% of Canadians living in a rural area are served by 8% of the country's general surgeons.[4] Up to one-third of these rural surgeons have a scope of practice defined as nontraditional general surgery core competencies. They are usually considered to be doing a good job.

The presence of a surgeon within rural and remote communities has been reported to improve trauma outcomes and effective emergent transfers to tertiary care.[4] Patients in such communities also required multidisciplinary management across several surgical disciplines, meaning many patients treated in rural centres obtained appropriate care within the capabilities of their local centres. It is imperative that we not interfere with this care system, but rather aim to bolster its functionality. Recruitment of surgeons with broad interests and diverse skill sets is important. Encouragement and further competency training should focus on enabling rural surgeons, not discouraging them. Can a general surgeon perform specialty-level care in orthopedics? The answer is probably not for technically difficult cases. But not all fractures are difficult or technical for a surgeon performing fixation as part of their practice. Can a rural surgeon positively impact the outcomes of patients under their care? The answer is in, and scientifically the answer is yes. We must improve competency training so these surgeons are comfortable with all the ailments they see regularly, within their communities, and in a timely manner. Some of this endeavour is the responsibility of the Royal College, some is the burden of provincial licensing bodies, and all of it relies on us being supportive colleagues.

Edward J. Harvey, MD; Chad G. Ball, MD, MSc

Affiliations: Co-editors-in-chief, *CJS* (Harvey, Ball); the Department of Surgery, McGill University, Montréal, Que. (Harvey); and the Department of Surgery, University of Calgary, Calgary, Alta. (Ball).

Competing interests: E.J. Harvey is the cofounder and head of medical innovation of NXTSens Inc.; the cofounder and chief medical officer of MY01 Inc., and Sensia Diagnostics Inc.; and the cofounder and director of Strathera Inc. He receives institutional support from J & J DePuy Synthes, Stryker, MY01, and Zimmer. No other competing interests were declared.

Cite as: *Can J Surg* 2024 October 23;67(5). doi: 10.1503/cjs.011324

References

1. *Dumesnil* v *Dr Jacob*, 2024 MBCA 4.
2. Pollett WG, Harris KA. The future of rural surgical care in Canada: a time for action. *Can J Surg* 2002;45:88-9.
3. Ma O, Verhoeff K, Purich K, et al. Characterizing Canadian rural general surgeons: trends over time and 10-year replacement needs. *Can J Surg* 2023;66:E439-47.
4. Glass L, Davidson M, Friedrich E, et al. Defining the Canadian rural general surgeon. *Can J Surg* 2024;67:E129-41.