SURGICAL CARE IN RURAL CANADA: TRAINING AND PLANNING FOR THE FUTURE

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Abstract • Résumé

The survey results reported by Chiasson and Roy in this issue (see pages 1447 to 1452) document a growing problem with the provision of surgical services in rural western Canada. Recognizing the need to improve access to surgical services in rural communities, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada have proposed guidelines for training family physicians in resuscitative and surgical techniques as well as in the safe transfer of seriously ill patients to specialized facilities. It is hoped that these guidelines will provide the basis of a national policy for general-practice training that will improve the standard of surgical care in rural communities.

Les résultats de sondage dont Chiasson et Roy font état dans ce numéro (voir pages 1447 à 1452) illustrent un problème croissant que pose la prestation de services de chirurgie en milieu rural dans l'Ouest du Canada. Reconnaissant qu'il faut améliorer l'accès aux services de chirurgie en milieu rural, le Collège des médecins de famille du Canada et le Collège royal des médecins et chirurgiens du Canada ont proposé des lignes directrices sur la formation des médecins de famille en techniques de réanimation et de chirurgie, ainsi que sur le transfert sans risque de patients gravement malades dans des établissements spécialisés. On espère que ces lignes directrices serviront de base à une politique nationale sur la formation en pratique générale qui améliorera le niveau des soins chirurgicaux en milieu rural.

In this issue (see pages 1447 to 1452) Drs. Patrick M. Chiasson and Peter D. Roy report the findings of their survey on the provision of surgical and anesthesia services in rural areas of Alberta, British Columbia, the Yukon Territory and the Northwest Territories. They previously reported on general surgical needs and practice patterns in rural Nova Scotia.[1] The present study was conducted by means of a questionnaire mailed to the administrators of 148 small hospitals in the study regions that had no more than 50 beds or were serving populations of 15 000 or fewer.

Although results obtained by questionnaire are generally considered to have a low scientific value, the 82% response rate obtained by Chiasson and Roy through two mailings and a telephone follow-up is to their credit and affords a reasonable picture of the extent of surgical and anesthesia services provided in rural western Canada. Although it would be hard to avoid concerns about objectivity in a study of this kind — for example, whether bias was introduced by asking administrators rather than patients whether the delivery of surgical services by their facility was satisfactory — the use of a questionnnaire was in this instance an appropriate method of investigation.

Of the 121 hospitals whose administrators replied to the questionnaire 101 met the study inclusion criteria. Surgical services were provided in 56 (55%) of the responding hospitals, of which 45 (80%) reported that some surgical services were provided by general practitioners (GPs). In 33 hospitals (59%) surgical services were provided by GPs with limited additional training in surgery, and in 15 (27%) these services were provided exclusively by GPs. Of the responding administrators 74 (76%) were satisfied that their community's needs for basic surgical services were being adequately met.

Chiasson and Roy's study raises a concern about the availability of general surgeons in rural communities and the attrition that will naturally follow from the fact that approximately 50% of general surgeons in Canada are already over 55 years of age.[2] In my experience most GPs in rural and remote areas confine themselves to a number of basic procedures in which they feel competent. Unfor-

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tunately, some rural physicians may feel forced by community or peer pressure to attempt procedures for which they have inadequate training or experience, and thus create a hazardous situation for the patient. (Such horror stories are also encountered in the specialist's world.) Moreover, now that rotating internships are no longer available in medical training, the breadth of experience of new graduates is likely to be more limited than it once was; one certainly gains the impression, for example, that currently qualifying GPs are less willing to attempt intra-abdominal surgery than their predecessors. Suitable guidelines would help rural practitioners to be judicious in the interventions they attempt.

The possibility of providing training that would enable GPs in rural communities to provide surgical services has been the subject of discussions between the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada during the past year. These discussions have yielded a proposed set of guidelines for training family physicians in resuscitative interventions, certain diagnostic and surgical services, and the safe transfer of seriously ill patients to specialized facilities.[3] The proposal states that "elective general surgery lies normally in the domain of the certified general surgeon, except in those circumstances where the family physician with added surgical skills is acting within the parameters of the document"[2] and recognizes that needs for particular services such as cesarean section and orthopedic services will vary from region to region, depending on the proximity of referral centres. The guidelines are intended to form the basis of a national policy whose implementation will begin with pilot projects in selected areas.

The teaching of this new curriculum would be overseen by the directors of general surgery and family practice residency training programs. Specific surgical skills such as excision of skin lesions and drainage of abscesses would be taught, and the American College of Surgeons' course on advanced trauma life support would be a fundamental component of training in resuscitative procedures.

The guidelines suggest that each hospital establish a protocol for emergency care to identify which patients should be transferred immediately to another facility. Three categories of patients are defined: (1) those with a life-threatening condition (e.g., a ruptured aneurysm) for whom the chance of survival is considered somewhat remote; (2) those whose condition (e.g., a compression fracture of the spinal cord or severe compound fracture of a limb) needs to be stabilized before they are transported to another facility; and (3) those whose injury or condition is considered life threatening but for whom treatment by a properly trained family physician would be appropriate. It was agreed that acute conditions of the gastrointestinal tract would not normally constitute an immediate threat to life. For instance, a patient with a perforated duodenal ulcer could be managed with nasogastric suction, antibiotics and intravenous fluid before transportation.

The proposed guidelines of the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada currently form the basis for surgical training for physicians located in rural areas. As yet no formal training programs have been developed from these guidelines: this would appear to be the next logical step.

The challenge of providing reasonable and adequate surgical care for Canadians living in rural areas urgently needs to be addressed by generalists and surgeons alike. People living in rural communities should have reasonable access to specialist services; they should also have an acceptable range of diagnostic and surgical procedures available to them through their local facility. This requires that a healthy supply of general surgeons be trained to meet these needs and raises a further problem: as general surgeons in rural areas approach retirement, there appear to be fewer newly qualified general surgeons to take their place. This is a continuing problem across Canada, and the recruitment of suitably trained general surgeons is becoming a critical issue. Chiasson and Roy's study helps to put this problem in perspective.

References

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