Doctors for Rural Canada: Progress on the Rural Road Map

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Bella Coola woman stays in tent waiting to deliver baby in Williams Lake

Costs for maternity patients to travel and stay outside the valley are not covered
VIBERT: Yarmouth hospital crippled by exodus of anesthesiologists

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Disagreements lead to N.S. docs missing out on anesthesiology training

Officials pushing for the use of family practice anesthetists have faced resistance
Population density and distribution of hospitals in Canada (and the UK)

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HEALTHCARE ACCESS IN RURAL CANADA

- Significant attrition of small-volume rural surgery and maternity care programs over the past 20 years, leading to diminished access to care
  - e.g. loss of 5/20 rural surgical programs in BC from 2000 to 2004\(^1\)
- Policymakers have focused on transporting patients to urban centres
  - Patients bear most of the burden for travel planning and associated costs
  - Indigenous populations are disproportionately affected
  - Loss of essential skills in rural hospitals
  - Large centres unable to absorb caseload

\(^1\) Iglesias and Jones Can J Rural Med 2006
Bellwether Procedures: associated with the ability of hospitals to perform all obstetric, general, basic, emergency, and orthopaedic procedures.  
- Cesarean delivery  
- Appendectomy  
- Laparotomy  
- Treatment of open fractures  
Hospitals should provide access to these procedures within 2 hours of a patient’s home  
While high volume is important for complex cases, the same is not true for low complexity procedures.  
There is a cost to not providing timely access to urgent surgical interventions  

2. Ibrahim et al. JAMA 2016  
3. NG-Kamstra et al. World Bank Blogs 2016
ADVERSE OUTCOMES IN RURAL CANADA

- Life expectancy decreases with increasing rurality\(^1\)
  - Male: 77.4 yr in cities vs 74.0 yr in rural areas
- Rurality is associated with unique health challenges as well as poorer access to care\(^2\)
- Adverse outcomes increase for patients further away from care:
  - **Perinatal mortality in Western Canada:** 18 per1000 births for women 240+ minutes from services\(^3\)
  - **Trauma mortality in Quebec:** Prehospital or ED mortality is over three times greater for trauma patients treated in a rural ED\(^4\)
  - **Trauma mortality in Ontario:** Adjusted odds of ED death among those surviving to hospital was 3.5 times greater in regions >1 hour from a trauma center\(^5\)

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1. DesMueles and Pong CIHI 2006
2. Gryzbowski et al. BMC Health Serv Res 2011
3. Fleet et al. BMJ Open 2019
Challenges

Volume and quality
Regionalization vs centralization
Maintenance of competence
Recruitment and retention
Data gaps—health workforce, outcomes
Education for rural family medicine generalist
Advancing Rural Family Medicine
Focused literature review of peer and grey literature focused on Canada with international policy reports.

www.cfpc.ca/arfm

Released 2016
Rural And Urban Family Medicine Training Sites
Fall 2016: 409 Sites

https://www.ic.gc.ca/eic/site/bsf-osb.nsf/eng/br03396.html
DIRECTION 1
Social Accountability of Medical Education

DIRECTION 2
Policy Alignment

DIRECTION 3
Rural-specific Practice Models

DIRECTION 4
Rural Research

Improving the health of rural and remote communities in Canada
Social Accountability Pentagram

Engage Key Stakeholders and aligned groups

- **Collaborative Advisory Group for General & Family Practice Anesthesia (CAGA)**
  - To represent the interests of general and family physician within The College of Family Physicians of Canada (CFPC) and its member interest group, the Society of Rural Physicians of Canada (SRPC) and the Canadian Anesthesiologists' Society (CAS) about the issues relevant to these members.
Potential solutions

Support for regional ob, surgical and anesthesia services by pentagram partners
Training for enhanced surgical skills
Support for role specific anesthesia training and maintenance of competence
Mentorship, exchanges
Creation of a professional home
Telehealth