

(Mandate & Membership–March 31st, 1999)

CFPC Working Group on Postgraduate Education for Rural Family Practice

Mandate and Membership

Draft! 31 March 1999

The College of Family Physicians of Canada Working Group on Postgraduate Education for Rural Family Practice was established by the CFPC with close consultation with the SRPC. The Working Group is a collaborative group of CFPC members and SRPC members, practising rural physicians and physicians involved in teaching students and residents for rural practice. Many of the members are involved in all of these activities. Practice locations include small remote rural practices such as Fogo Island and Marathon to practice in larger rural settings that involve GP anaesthesia, obstetrics and emergency work in addition to outpost medicine. This diverse group also includes family medicine residents, rural program co-ordinators, a postgraduate family medicine program director and a medical school associate dean as Royal College of Physicians and Surgeons representative.

The Working Group's mandate from the CFPC is as follows:

- #1 Describe the knowledge, skills and attitudes needed for rural family practice*
- #2 Describe the postgraduate training currently provided to prepare family medicine residents for rural family practice.*
- #3 Outline a core postgraduate curriculum for rural family practice*
- #4 Explore the potential for an advanced skills postgraduate curriculum for rural family practice:*
 - GP anaesthesia*
 - Obstetrics*
 - Surgery*
 - Psychiatry*
 - Other*

The goal is to develop a needs-driven, evidence-based, learner-centred, effective approach to educating family doctors with the appropriate knowledge, skills and attitudes to practice in rural communities. Both the process and the end result need to be co-operative and collaborative to be successful.

The following is presented as the work in progress to date:

Working Group 1st Teleconference – July 15, 1998
Working Group Meeting – October 16-17, 1998
Working Group Teleconference – December 1, 1998
Presentation and discussion at “Think tank on rural issues” CFPC Board – December 5, 1998
Working Group Teleconference – January 8, 1999
Presentation and discussion at “Dialogue on Education and Training of Rural Family Physicians”, CMA, CFPC, SRPC, RCPS, FMLAC, APMC, MCC, CAIR – January 14, 1999
Working Group Meeting – February 19-20, 1999
Working Group Teleconference – March 23, 1999
Final draft sent to CFPC Board and SRPC Council – April 1999
Discuss report highlights at SRPC meeting, St. John’s, NF - April 15, 1999
Present “Final Draft” to CFPC Board meeting, Victoria, BC - May 13, 1999

Membership List:

<i>Dr. James Rourke (Chair)</i>	<i>Goderich, Ontario</i>	<i>CFPC, SRPC</i>
<i>Dr. Con O’Maonaigh</i>	<i>Fogo Island, Newfoundland</i>	<i>SRPC</i>
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(Introduction – March 31st, 1999)

CFPC Working Group on Postgraduate Education for Rural Family Practice

INTRODUCTION

Draft! 31st March 1999

With 10 million square kilometres and only 28.8 million people, Canada has vast rural areas where providing accessible quality health care is a major challenge.

Canada has a very diverse population. More than 1 million Canadians of Aboriginal ancestry, 4% of the total population, are scattered from coast to coast. Nearly 300,000 live in isolated reserves.⁸ Fifty-six percent of Canada's Aboriginal people live in rural areas including reserves: 35.2% on reserves and 20.3% in non-reserve rural areas.⁹ By any measure, Aboriginal people have poorer than average health.

Numerous primary industries are based in rural Canada – mining, forestry, fishing and farming. All of these industries pose a higher risk of accidental injury and death for both workers, and in some instances such as farming, their families. Canada's rural people are older and in general have a lower income and educational status than their urban counterparts, and these factors have been shown to correlate with poorer health status overall.

In addition to the above populations, rural family doctors provide care for the many tourists who visit Canada's rural and remote areas each year. These people present with a full range of illnesses from poison ivy dermatitis to myocardial infarction as well as with injuries specifically related to activities such as skiing. A remarkable example was the worst bus accident in Canadian history which occurred near Baie-St. Paul, a community of 4,00 people with a small hospital.

Canada's rural health care providers are challenged not only by the populations that they serve but also by the barriers to access to specialist and technological support. These barriers include the sometimes enormous distances to travel, the often harsh climactic conditions which can delay or prevent it completely, particularly in difficult geographical settings, from the Maritimes to the west coast mountains. To provide

health care in these settings requires a practitioner with a specific knowledge base, skills set and attitudes relevant to the setting and population.

A commonly used definition of “rural” in Canada includes communities of up to 10,000 people. By this definition, 8,740,847 Canadians (30.3%) are rural.⁴ Rural people can also be defined as those living outside census metropolitan areas and census agglomerations.* By this counting method, 22.2% of Canadians (6,396,906) are rural people.⁶ (**Table 1 in Appendix 1**)

- A Census Agglomerate is defined as “a large urban area (known as the urban core) together with adjacent urban and rural areas (known as urban and rural fringes) that have a high degree of social and economic integration with the urban core. A CA has an urban core population of at least 10,000, based on the previous census.”⁵

Using the same definition of practice location, only 9.9% of Canada’s doctors – 4,775 family doctors (16.5% of Canada’s GP/GPs) and 756 specialists (2.8% of Canada’s specialists) – can be considered rural. (See Appendix 1 for further discussion)

Rural practice can be defined as “practice in non-urban areas, where most medical care is provided by a small number of general practitioners/family doctors with limited or distant access to specialist resources and high technology health care facilities.” [Rourke J. In search of a definition of rural. *Can J Rural Med* 1997;2(3):113-115]. Another functional definition is “medical practice outside of urban areas where the location of practice obliges some general/family practitioners to have or acquire procedure or other skills not usually required in urban practice.” [Faculty of Rural Medicine, Royal Australian College of General Practitioners] Appropriate education must be provided for physicians to practice under these circumstances.

In Canada, rural education initiatives at the postgraduate level have developed almost totally within provincial regions. The forces for education reform at this level have come from grassroots rural physicians’ input, pressure from rural practice groups within some provincial medical associations, educational leadership at some university medical school departments of family medicine, with some

support from general medical organizations and governments. As a result, a variety of family medicine training programs have been developed in response to regional needs and resources available.

There has been, however, no common curriculum for postgraduate education for rural family practice or for rural family medicine advanced skills. This has made it difficult for residents to identify and select appropriate portable yet specific postgraduate education for anticipated rural family practice. Availability and structure of postgraduate and special/advanced skills education for rural family practice is an area of particular concern for both practicing and prospective rural doctors.

Successful development of core postgraduate education for rural family practice and special advanced skills training is required to meet the health care needs of rural Canadians. Producing more physicians with the knowledge, skills and attitude for rural family practice will require involvement, collaboration, co-operation, and support of governments, medical schools, medical organizations and rural doctors.

This report provides both a **vision** and **recommendations** for **“Postgraduate Education for Rural Family Practice.”**

- Mandate #1, describes the “knowledge, skills and attitudes needed for rural family practice”. This section along with Appendix 3 “rural patient stories/physicians narratives” describes the essence of rural family practice.
- Mandate #2 describes the “current postgraduate education initiatives for rural family practice.
- Mandate #3 presents “recommendations for core postgraduate education for rural family practice”. This section provides 9 major and 41 specific recommendations for effective core education for rural family practice within the 2 year family medicine program. Important issues are highlighted in the discussion.
- Mandate #4 presents “recommendations for “postgraduate education for special/advanced rural family medicine skills.” This section provides 3 recommendations for special rural family medicine skills education and 13 for advanced rural family medicine skills education. Important issues are highlighted in the discussion.

Accessible, quality rural medical care requires an adequate number of appropriately trained rural doctors with an effective, supported rural health care team. Providing appropriate education for rural family practice is essential. Better recruitment and support of rural physicians and improved rural health care teams and infrastructure is also crucial to improving rural health care.

CFPC Working Group on Postgraduate Education for Rural Family Practice

MAIN REC – 31 MARCH 1999

Main Recommendations

Core Postgraduate Education

This report has nine major recommendations for effective core education for rural family practice within the two-year family medicine program.

1. Core undergraduate rural education experiences are necessary for all medical students.
2. Core postgraduate rural/regional community based rotations are desirable within all the programs along with sufficient rural elective opportunities for all residents.
3. Rural family medicine training streams should be developed as the appropriate postgraduate training for rural family practice.
4. Rural family medicine training streams should be community-based integrated programs with full academic support.
5. The learner-teacher dyad should be based on the preceptorship model for both family medicine and specialty-based educational experiences/rotations.
6. Competency in the knowledge, skills and attitudes for rural family practice should be the goal for rural family medicine residency training.
7. Hospital experiences or rotations should be appropriate for the residents' learning needs for future rural practice.
8. Universities should support and develop rural physician teachers as integral faculty members.
9. University faculty and programs should nurture and develop present and future rural family medicine residents.

Please turn to the section "Mandate 3" for the 41 specific recommendations and discussion of the important issues.

Special Rural Family Medicine Skills

There are three recommendations for postgraduate education for special rural family medicine skills and 13 for advanced rural family medicine skills.

1. Flexible additional postgraduate education for rural family practice should be provided to meet both learner and community needs.
2. Additional third year positions of flexible duration (usually 3-6 months) should be readily available for residents to develop special skills for rural family practice.
3. Rural physicians in practice should have ready access to appropriately funded special skills education opportunities of flexible duration (usually 3-6 months).

Advanced Rural Family Medicine Skills

1. Rural Canadians should have access to essential health services including anaesthesia, optimal maternity care, general surgery and other advanced skills such as psychiatry within or close to the communities.
2. Rural family physicians should continue to be trained in Advanced Rural Family Medicine Skills including general anaesthesia, general surgery, advanced maternity care including Caesarean section and other advanced skills such as psychiatry where there is a demonstrated need.
3. A defining principle of training programs in advanced skills for rural family physicians is the requirement that there be a single standard of care for both urban and rural Canada for the provision of these essential services for low-risk patients and procedures. The skill set is a shared one between family medicine and the specialty groups and the knowledge base within both programs should be rigorous.
4. The curriculum guidelines and standards for advanced rural family medicine skills should be recognized and developed by the College of Family Physicians, the SRPC and RCPS with input from appropriate specialist and associations.
5. The College of Family Physicians (and preferably conjointly with the Royal College with input from the licensing bodies) should accredit advanced rural family medicine skills training programs.
6. University medical schools should develop and provide advanced rural family medicine skills training programs based on both regional and national needs.
7. Advanced rural family medicine skills training programs should be developed with the appropriate resources and utilize regional and rural components and teachers as much as possible.
8. Advanced rural family medicine skills training positions should be accessible to committed applicants, both third year family medicine residents and re-entry (practising) physicians.
9. Training should be competency-based rather than solely time-based, but most often will require a range of 6-12 months.
10. Learning objectives based on nationally developed curriculum guidelines and standards should be used for formative (in training) and summative (completion) evaluations.
11. The individual physician's training program for advanced rural family medicine skills should also reflect the learner's and the community's needs.
12. Medical schools providing Advanced Rural Family Medicine Skills training should provide a certificate of competence to physicians who satisfactorily complete their program.
13. The medical schools providing Advanced Rural Family Medicine Skills Training Programs should develop formal CME and maintenance of competence programs.

Please turn to the section "Mandate 4", parts I and II for further discussion for the important issues involved.