THE SOCIETY OF RURAL PHYSICIANS

POLICY AGENDA / OUTLINE

I. GUIDING PRINCIPLES:

1. Our primary focus is to promote high quality medical care in rural Canada.

2. Patients should receive medical care in their own communities whenever possible. This results in medical, psychological, social and economic benefits.

3. Quality medical care depends on adequate numbers of sufficiently trained physicians who are willing to live and work in rural areas, and who have sufficient support to practice quality medicine. If physicians are adequately trained for rural practice, have adequate professional support as well as personal/social support, and have reasonable working conditions and remuneration, many of the current problems with recruitment and retention of physicians in rural communities would be solved.

4. Policies should be researched as much as possible so that they accurately represent available evidence, and then widely discussed before final drafting so that they represent consensus opinion of rural physicians. (I suspect that in most cases there is little research evidence to go on.)

5. As much as possible, the SRP needs to work co-operatively with existing medical organizations to achieve its goals.

6. The definition of "Rural Practice" should be based on function as well as geography or population. For example, the Royal Australian College of General Practice Faculty of Rural Medicine defines rural practice as medical practice outside urban areas, where the location of the practice obliges some general practitioners to have, or to acquire, procedural and other skills not usually required in urban general practice.

II. EDUCATION OF RURAL PHYSICIANS:

1. Rural Medicine is sufficiently different from other areas of medicine that it can be considered a specialty in its own right, requiring a unique set of knowledge, skills, and attitudes in order to practice it well and with confidence. (This implies a Core Curriculum of training which would be generic to any rural physician or location of practice, including emergency medicine, obstetrics procedures, minor surgery and orthopedics.)

2. The WONCA Policy on Training for Rural Practice provides excellent guidelines for rural medical education and other issues related to recruitment and retention of physicians in rural communities.

3. Training for Rural Medicine should involve a continuum from pre-medicine, through undergraduate medical training, to postgraduate training and continuing medical education:

3.1 PREMEDICAL EDUCATION:

Medical students of rural origin are more likely to enter rural practice, therefore mechanisms to encourage rural students to enter medicine should be developed, including:

- Promotion of medical careers to rural secondary schools.

- Support for rural students in the biomedical sciences.

- Specific mechanisms in the selection process for medical school to ensure that rural origin students are recruited into medical schools

3.2 UNDERGRADUATE MEDICAL EDUCATION:

Significant and early exposure to rural medicine and rural practice should be encouraged in all students.

Appropriate rural role models should be identified and their expertise exploited during the undergraduate years.

3.3 POSTGRADUATE MEDICAL EDUCATION:

A core curriculum in rural medicine needs to be defined. Family medicine residency programs need to be structured so that residents interested in rural medicine are able to pursue a focused program to meet the objectives of the core curriculum both in family medicine and in rural medicine. This may require support for an additional year of training beyond the current two year residency program in order to ensure full and comprehensive training for rural practice.

3.4 CONTINUING MEDICAL EDUCATION:

Recognizing that medical education is a continuous process and that the demands of rural practice especially require the ability to keep current and upgrade skills, the provincial governments, medical schools, and referral centres need to ensure access to appropriate CME programs for rural physicians.

In accordance with the principles of adult education, rural physicians are best able to define their own CME needs. All medical schools should have a mechanism, such as an advisory group of rural physicians, to appropriately define, design and deliver CME programs for rural physicians.

4. There needs to be adequate opportunity for physicians (both residents and physicians in practice) to acquire additional advanced skills appropriate for rural / remote practice (e.g. operative obstetrics, major surgery, anesthesia, critical care, endoscopy. exercise treadmill testing, diagnostic imaging).

III. LICENSING OF RURAL PHYSICIANS:

1. Provincial licensing barriers should not impede the flow of adequately trained or experienced MDs into rural practice. (This implies developing some national standard for certification of physicians for rural practice, or at least working with the Federation of Medical Licensing Authorities to decrease mobility barriers while meeting their legislated mandate to protect the public. Establishing a College of Rural Medicine with certification criteria would accomplish this, but it is likely more practical to have a core curriculum in rural medicine recognized by the College of Family Physicians and FMLA.)

IV. WORKING CONDITIONS OF RURAL PHYSICIANS:

1. Guidelines for hours of work / on call / on duty time including the right of the individual professional to define his or her own limitations, and the right to remove oneself from work when fatigue will affect clinical judgement.

2. Adequate remuneration, including mechanisms for payment for work in administration, supervision of allied health professionals, and for on call / on duty time.

3. Funding for CME.

V. PROFESSIONAL SUPPORT:

1. The development and maintenance of diagnostic and treatment services that can be provided locally needs to be encouraged so that patients can be cared for in their home communities. Not only do patients derive some medical benefit and considerable psychological and social benefit from being able to stay in their home communities, but there are substantial economic savings if patients do not have to travel for services.

2. Where appropriate, visiting specialist programs and the development of formal liaison and joint programs with specialty departments should be encouraged. Examples would be in the areas of obstetrics, surgery, anesthesia and critical care medicine. This provides for better patient care as well as support for physicians to use the full range of their training.

3. Most of the faculty of medical schools should have sufficient experience with rural and regional communities to be familiar with the medical needs of these populations. We need to develop better mechanisms (e.g. defined specialist groups to provide backup to defined geographical areas or rural practices) to foster consistency in liaison with urban centres, better professional relationships between rural and tertiary care physicians, better referral patterns and more reliable support.

4. Medical schools should encourage specialty residents to receive part of their training in regional centres to foster more understanding of the realities of rural and community practice among specialists.

>5. A locum system should exist so that rural physicians are able to find coverage for vacations, sickness and continuing medical education without undue difficulty.

6. Telecommunication ability for Internet access and participation in telemedicine programs for patient care and for continuing medical education should be available without cost to the physician.

VI. ALLIED HEALTH PERSONNEL:

1. Need for appropriately trained RNs and ambulance staff.

2. Role of nurse practitioners.

3. Need for physiotherapists, occupational therapists, mental health workers, etc.

VII. RURAL FACILITIES:

1. Patients are best treated in their home communities for both medical and economic reasons. Local hospital services must be supported as much as possible so that patients are not transferred for services which could be provided locally (this includes emergency services, inpatient acute and long term care beds).

3. Need for physician-based emergency medical services, including equipment and support personnel, to provide equivalent emergency care as in urban areas.

4. Reasonable distances / travel times to 1st provider or physician-based services.

5. Standards for patient stabilization prior to transport, including the ability to hold and treat patients until safe for transfer.

VIII. RESEARCH

1. Diagnostic and management methods need to be tested in the unique context of the rural setting.