



## Rural surgical service delivery

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**A**s researchers and physicians working in surgical service delivery in British Columbia, we would like to share some of the highlights of an Invitational Meeting on Rural Surgical Services (June 22–23, 2007, Vancouver, BC), hosted by the Centre for Rural Health Research. The goal was to share research, policy and educational initiatives among key stakeholders in rural surgical care delivery. Attendees included representatives from BC Health Authorities, the BC Medical Association (BCMA), the University of British Columbia (UBC), Researchers, general practitioner (GP)–surgeons and the BC Reproductive Care Program (BCRCP).

All participants agreed with the urgency and fundamental need to address rural surgical service delivery. The delivery of rural surgical care is an urgent priority both because of vanishing local access to surgical care for rural residents and its integral link with emergency, acute and maternity services. GP–surgeons support small volume rural programs in communities typically of 5 – 15 000 residents. Mixed models of specialist surgeons and GP–surgeons typically service communities of 15 000 – 25 000. The current crisis in rural human health resources is an immediate and central threat to all of these small-volume surgical programs.

The meeting began with both poster and slide presentations by most participants. Large quantities of published and nonpublished literature pertaining to small-volume surgical program demographics, models, scope and outcomes, as well as future research, were summarized. Health authorities were particularly interested in models that

could cost-effectively sustain rural recruitment and retention, and maternity and surgical care in small-volume rural hospitals. Academic institutions were open to implementing a sustainable GP–surgical training program. This could stabilize the delivery of surgical services in communities too small to sustain specialist surgical care but that have traditionally been and are currently served by GP–surgeons.

The meeting finished with 8 recommendations for rural surgical service delivery:

1. **Current services need to be sustained.** Considering the inextricable links between sustainable maternity care and the current evidence of safety in outcomes, there is enough evidence to currently support and sustain small-volume rural surgical programs where they now exist.
2. **There is a need for a rural surgical skills program for family physicians.** Academic institutions have a social responsibility to train physicians to meet the needs of rural residents. UBC should offer a formal accredited training program in surgery for rural family physicians. This should include a standardized, portable skill set and a formal certificate of completion of a training program suitable for credentialling. Training programs of family practice anesthesia provide a working template for both the training and credentialling of such a program.
3. **Curriculum should be rurally relevant.** Graduates should be able to competently assess, manage and treat common surgical conditions already identified in the literature for low-risk patients. Graduates

should further extend their knowledge of risk stratification for rural patients and the differences in rural and urban patient care.

4. **There is a need for a broad scope of practice.** Low-volume programs need a broad scope of practice, which has traditionally been part of a GP–surgeon skill set and what we know to be safe with available literature, to both meet the needs of the community and maintain surgical volumes.
5. **Ongoing professional support is integral to sustainable small-volume surgical programs.** Recognizing that a significant factor in the sustainability of these low-volume surgical programs is ongoing professional support, a formal support program addressing recruitment, retention, matching communities with GP–surgeons, vacation relief and a rural surgical support network should be funded.
6. **Different models need to be incorporated into service delivery.** Local access by low-risk patients to low-risk surgical services performed by GP–surgeons and regional access to specialist services for higher risk patients is a model that has existed for decades and is an extension of the health care delivery system that already exists in many other areas of rural medicine. Both models should be integrated into future health care planning.

7. **Multidisciplinary teams are essential.** The success of rural surgical programs relies on multidisciplinary teams, including nursing, laboratory and transport personnel. Recruitment is positively affected by the presence of a rural surgical program. Specialist surgeons play an important role in mentorship, continuing education, itinerant surgery, consultation and case reviews. Strong relationships between regional surgeons and GP–surgeons are imperative for the survival of small-volume programs.
8. **The need to build research capacity.** There is a need for an interdisciplinary team of key stakeholders to build and direct research capacity as well as facilitate knowledge translation to policy-makers.

Consequently, plans were made to further develop a curriculum to train GP–surgeons, to locate an appropriate training site and to continue to develop future research that will provide an evidence base for the design and provision of safe, sustainable surgical services in rural communities.

We are eager to share the outcome of this important meeting, which signifies a crucial step in sustaining rural surgical services. We remain committed to continuing to define and implement the necessary steps to provide quality sustainable rural surgical care.

## Doctors Speak Out

Podium — Letters to the Editor — Editorials

We invite physicians to speak out on issues that concern them. Send your submissions to Suzanne Kingsmill, Managing Editor, *CJRM*, Box 1086, Shawville QC J0X 2Y0; [cjrm@lino.com](mailto:cjrm@lino.com)

## Les médecins s'expriment

La parole aux médecins — Lettres à la rédaction — Éditoriaux

Nous invitons les médecins à commenter les questions qui les intéressent. Faites parvenir vos textes à Suzanne Kingsmill, rédactrice administrative, *JCMR*, BP 1086, Shawville (Québec) J0X 2Y0; [cjrm@lino.com](mailto:cjrm@lino.com)