Working to the breadth of our licence

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Perhaps nowhere as much as in rural practice do physicians work to the breadth of their licence. We do more. This has been documented for general practice, in which doctors in the most remote areas have 80% greater breadth of practice than their urban counterparts,[1] and is anecdotally reported for rural specialties. We practise these skills for the joy of providing needed services. We hope to provide better outcomes for our patients and community. One of the skills within the breadth of general practice is cesarean delivery. Between 2007 and 2010, a quarter of women in rural Canada underwent cesarean delivery performed by practitioners in their communities who were not obstetrician/gynecologists.[2] Is this safe? We used to think it was. Now we know it is.

That proof of good outcome is buttressed by the article by Grzybowski and colleagues in the current issue.[3] This well-constructed study included 9174 births in regions where cesarean delivery, when needed, was provided by general practitioners (GPs) with enhanced surgical skills. To prevent bias from more complicated cases sent to the city for delivery, the authors attributed results to the rural hospital, regardless of where the patient delivered.[3]

Outcomes for surgical services provided by GPs compared favourably to those provided by obstetricians.[3] This study supports the joint position paper on rural maternity care published in this journal.[4]

Do not make the error of believing that safe rural maternity services can be replaced by travel, plus urban maternity services. The travel part is a problem, because humans make for fragile cargo. Data from the Canadian Institute for Health Information show that prolonged travel increases rates of prematurity.[2] Furthermore, a study from Washington state by Nesbitt and colleagues[5] showed that

> women from communities with relatively few obstetrical providers in proportion to number of births were less likely to deliver in their local community hospital ... Women from these high-outflow communities had a greater proportion of complicated deliveries, higher rates of prematurity, and higher rates of neonatal care than women from communities where most patients delivered in the local hospital.[5]

We have ongoing political challenges in ensuring that policy-makers are aware and accepting of the fact that closure of rural maternity units causes not only inconvenience for patients, but also poorer (and more expensive) outcomes. These poor outcomes are mostly endured by the women and their children in urban neonatal intensive care units. By publishing much-needed research on this topic, our journal is building on that awareness.

Here too, perhaps working to the breadth of our licence, it is meet and good.

REFERENCES

1. Hutten-Czapski P, Pitblad R, Slade S. Short report: scope of family practice in rural and urban settings. *Can Fam Physician* 2004;50:1548-50.
2. *Hospital births in Canada: a focus on women living in rural and remote areas.* Ottawa (ON): Canadian Institute for Health Information; 2013.
3. Grzybowski S, Stoll K, Kornelsen J. The outcomes of perinatal surgical services in rural British Columbia: a population-based study. *Can J Rural Med* 2013;18:123-9.
4. Joint Position Paper Working Group. Joint position paper on rural maternity care. *Can J Rural Med* 2012;17:135-41.
5. Nesbitt TS, Connell FA, Hart LG, et al. Access to obstetric care in rural areas: effect on birth outcomes. *Am J Public Health* 1990;80:814-8.