Competency in rural practice

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In response to the Cochrane report,[1] which arose from a situation where diagnostic images were being interpreted by a physician who did not have the necessary training, the BC government has proposed a new profession-wide quality assurance (QA) process.[2] A minimum number of hours performing anesthesiology, babies delivered, cesarean deliveries performed and so on, will be expected. Although we fully support a QA system, this particular approach has the potential for unintended consequences that could damage family practice in rural settings.

Rural family practice is substantially different from urban family practice by virtue of its generalism. The rural family physician may run a clinic, deliver a baby, give an anesthetic, manage the oncology outreach program and cover the emergency department within a single day. In rural practice, generalism is the norm. Because so many facets of medicine are involved, the numbers of specific procedures performed are typically low compared with those of a physician with a single area of expertise. Despite these low numbers, the outcomes of rural health care have been consistently shown to be good in obstetric and surgical reviews.[3–5]

The proposed use of numbers to determine whether rural physicians are current or competent has no evidence to support it in the literature. There is, however, evidence to show that use of numbers for a QA system has done substantial damage to rural health care services historically.[6–9]

Some years ago, The Society of Obstetricians and Gynaecologists of Canada (SOGC) recommended that a minimum of 25 deliveries per year was necessary for a physician to remain competent in obstetrics.[10] The College of Physicians and Surgeons of Saskatchewan introduced this requirement, with the consequence that most rural physicians left maternity care. Saskatchewan went from 80% of births being attended by family physicians to less than 20% of births (JANUS database of The College of Family Physicians of Canada: unpublished data).[11–13]

Most important, despite the SOGC subsequently reversing its position and explicitly stating that there is no minimum number of deliveries required to remain competent,[14,15] the damage was done, and the number of deliveries by family physicians in Saskatchewan never recovered.

Rural physicians are generalists. Attempting to measure specific skills using a numbers-based QA system ignores the realities of the broad scope of rural practice, the teamwork and the transference of skills among procedures. Such a system has the effect of shutting down services rather than enhancing and expanding the services provided to rural populations. The loss of any part of a rural medical community has consequences for the entire population that are not seen in the urban environment.[16,17] In the risk-averse climate that now exists, to be advised that your numbers have not reached an arbitrary threshold will be sufficient to cause many rural physicians to cease providing that service, as was seen in Saskatchewan.

There is no evidence that numbers support QA in rural Canada, and numbers-based QA systems have the potential to cause substantial damage. There are other very successful models for continuous quality improvement, such as the MORE^{OB} Program (Managing

Obstetrical Risk Efficiently; moreob.com) and The CARE Course (The Comprehensive Approach to Rural Emergencies; thecarecourse.ca), which should inform governments if they intend to protect and promote rural health care.

REFERENCES

1. Cochrane DD. *Investigation into medical imaging, credentialing and quality assurance. Phase 2 report.* Vancouver (BC): BC Patient Safety and Quality Council; 2011. Available: www.health.gov.bc.ca/library/publications/year/2011/cochrane-phase2-report.pdf (accessed 2014 Mar. 11).
2. Slater J, Bloch-Hansen E. Changes to medical staff privileging in British Columbia. *BCMJ* 2014;56:23-7.
3. Centre for Rural Health Research. *Proceedings from the Invitational Meeting on Rural Surgical Services.* 2007 June 22–23; Vancouver, BC.
4. Iglesias S, Grzybowski S, Klein MC, et al. Rural obstetrics. Joint position paper on rural maternity care. Joint Working Group of the Society of Rural Physicians of Canada (SRPC), The Maternity Care Committee of the College of Family Physicians of Canada (CFPC), and the Society of Obstetricians and Gynaecologists of Canada (SOGC). *Can Fam Physician* 1998;44:831-43.
5. Klein MC, Spence A, Kaczorowski J, et al. Does delivery volume of family physicians predict maternal and newborn outcome? [see comment]. *CMAJ* 2002;166:1257-63.
6. Klein MC. The Canadian family practice accoucheur. *Can Fam Phys* 1986;32:533-540.
7. Allen VM, Jilwah N, Joseph KS, et al. The influence of hospital closures in Nova Scotia on perinatal outcomes. *JOGC* 2004;26:1077-85.
8. Klein MC, Reynolds J, Boucher F, et al. Obstetrical practice and training in Canadian family medicine: preserving an endangered species. *Can Fam Physician* 1984;30:2093.
9. Rosenblatt RA, Reinken J, Shoemack P. Is obstetrics safe in small hospitals? Evidence from New Zealand's regionalised perinatal system. *Lancet* 1985;2:429-32.
10. Number of births to maintain competence. In: *SOGC Clinical Practice Guidelines.* No. 58; November 1996.
11. *Giving birth in Canada: a regional perspective.* Ottawa (ON): Canadian Institute for Health Information; 2004.
12. *Giving birth in Canada: providers of maternity and infant care.* Ottawa (ON): Canadian Institute for Health Information; 2004.
13. *Indicators report 2007 for every health region.* Ottawa (ON): Canadian Institute of Health Information; 2007.
14. Joint Policy Statement. Number of births to maintain competence. *JOGC* 2002;(113).
15. Jackson WD, Daimond MR. Procedural medicine: Is your number up? *Aust Fam Physician* 1993;22:1633-6;1639.
16. Klein M, Christilaw J, Johnston S. Loss of maternity care: cascade of unforeseen dangers. *Can J Rural Med* 2002;7:120-1.
17. Klein M, Johnston S, Christilaw J, et al. Mothers, babies and communities. Centralizing maternity care exposes mothers and babies to complications and endangers community sustainability. *Can Fam Physician* 2002;48:1177-9.