President's message. Rural generalism

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When I was a child living in a rural community, rural generalists cared for most of the medical needs of the community. Simple and complex obstetrics, a wide variety of surgical procedures, emergency care, and most inpatient and outpatient care were provided by generalists. It was a somewhat uncommon event when a person left the community for medical care in the big city. In the last few decades this has changed. Our approach to health care has become increasingly specialized, and technology sometimes replaces clinical skills. This has resulted in health systems that are unduly expensive, not patient-centred and not meeting community needs. It has resulted in physicians who are overly specialized, or who are unwilling or unable to work to the full scope of their training. It has resulted in training programs that don't meet the needs of communities for generalists to provide the comprehensive, longitudinal medical care that community members require.

The first World Summit on Rural Generalist Medicine was held in Cairns, Australia, in October 2013. Out of this meeting came a consensus statement that has undergone dissemination and refinement over the last year and has been endorsed widely around the world. The Cairns Consensus Statement on Rural Generalist Medicine creates common principles that may be used and adapted by each participating country: 1) comprehensive primary care for individuals, families and communities; 2) hospital inpatient and/or related secondary medical care in the institutional, home or ambulatory setting; 3) emergency care; 4) extended and evolving service in 1 or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues; 5) a population health approach that is relevant to the community.[1]

Canadians living in rural communities deserve this approach to their medical care. Our patients need physicians who know them and their illnesses, who understand their social circumstances, who have an appreciation of them as individuals, and who are able to provide the bulk of medical services close to home with competence and confidence. Too-often-exaggerated concerns about medical "risk," lack of training or lack of confidence among rural physicians, and policies implemented at provincial or regional levels have led to the loss of services in our rural communities.

We need better tools for assessing community need and for determining whether existing or proposed programs meet this need. We need rurally relevant research so that when the quality or appropriateness of our care is questioned, evidence may trump urban-specialist or administrator opinion. We need to choose individuals for our training programs who are most suited to be rural generalists. We need better educational programs for both current and future rural generalists. We can do better for rural Canada.

REFERENCE

1. Cairns consensus statement on rural generalist medicine. Final draft version May 22, 2014. Available: www.srpc.ca/PDF/CairnsConsensus.pdf (accessed 2014 Dec. 4).