



## Summit on Rural Surgery and Maternity Operative Delivery Organization For Action Workshop

### Background

Few specialists live and work in rural and remote Canada – a part of the world with sizable geographic and demographic importance. Yet these non-urban communities have needs for surgical and obstetrical care close to home, needs increasingly difficult to meet given the sub-specialization happening in the medical world. Historically, access to surgical care and cesarean section in rural communities has been provided by 1) a mix of courageous rural General Surgeons skilled in many other disciplines such as orthopedics, gynecology, endoscopy etc; and, 2) by general /family practitioners (GP/FP) most of whom acquired their specialized knowledge skill sets in an informal and non-accredited manner. As the scope of training for General Surgery has narrowed and the graduates have chosen to settle in regional centres with large call groups, the GP/FP surgeons have been a bulwark against the steady erosion of rural maternity services over decades. Additionally, GP/FP surgeons have provided a host of other essential capabilities to rural communities by maintaining a “surgical culture” that allows effective emergency, resuscitative and surgical evaluative skills where they are most needed.

The voluntary collaboration of the partners in the ESS (“Enhanced Surgical Skills”, used interchangeably with “GP/FP Surgeons”) Networking Group has provided a platform over the last four years to encourage and support rural surgery and obstetrical operative delivery. This would not have been possible without the priceless funding and administrative aid of RccBC, RPAP and CORRP Saskatchewan. Regardless, the recent Joint Position Paper on Rural Surgery and Operative Delivery and the Curriculum and Evaluation paper, while coming from a welcome cooperation between specialist and non-specialist “field” organizations, does not ensure Canada’s rural communities have access to caesarean section, maternity and surgical services. Much remains to be done to carry forward the promising ideas in the Joint Position Paper. For that we need, among other initiatives, an **“organization for action”** plan.

### Goals

***“...to propose an organizational solution that would include the stakeholders and would encourage robust initiatives to support and sustain rural surgery and operative delivery services...”***

To this we might add:

***“...The solution should include not only how the program will be accredited but also how rural GP/FP Surgery is to be maintained within Networks of specialist surgeons and ESS Family Physicians.”***

By “accredited” we might mean a national recognition of the training to produce GP/FP surgeons. Since the GP/FP surgeon will be trained by and working with fellowship surgeons to a significant degree, one would anticipate a strong role played both by the College of Family Physicians of Canada (CFPC) and of the Royal College of Physicians and Surgeons of Canada (RCPSC).

By “maintained” we would include such topics as continuing medical education, seeking funding for and overseeing pilot rural surgical networks (with fellowship and GP/FP surgeons working closely both locally and regionally), research, advocacy at the provincial and national level, and many other non-accrediting functions.

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Accordingly, this workshop will look in to these two issues sequentially. However, since the issues are intertwined we can anticipate a certain amount of reference back and forth as discussions evolve.

**ACCREDITATION:** While the obvious formal organization ultimately accountable for accreditation and certification of family practice programs and practitioners is the College of Family Physicians of Canada, the networks of care that ESS practitioners will engage in present unique challenges to the regular structures of the CFPC. We must remember that ESS services have a long and impressive record of safe and necessary services, as well demonstrated in the literature. While administrative and policy choices have led to the current crisis of attrition, these are not intentional nor are they justified by quality concerns. Indeed, supporting and replacing such practitioners while ensuring continuous quality improvement will be best served by fostering the required networks through the **ADVOCACY** mechanisms discussed below. The advocacy and accreditation systems will need to be sensitively intertwined through the effective engagement of all the necessary partners in **both** processes.

- 1) What is the best form of accreditation to ensure the programs producing newly minted GP/FP Surgeons are functioning to ensure graduates that are appropriately trained and recognized for the work that they will do?
- 2) How will the accreditation of the programs be structured?
- 3) Which organizations will be responsible for the national accreditation?
- 4) What are the next immediate steps to establish the inter-organizational relationships necessary to accomplish a system for accreditation?
- 5) What form of certification will graduates bear when they leave the initial program and what forms of continuing professional development will be required to maintain that certification?

**ADVOCACY** ([see Appendix 1](#)) The relatively informal “network” of organizations and advocates that have worked on coordinating the “Five Pillar” national strategy (joint position paper, curriculum, CFPC CoP, credentialing/privileging and communities of practice) has brought us to this point. As we look forward to the next steps in ensuring enduring and sustainable services to rural Canadians, it is clearly time to reflect on establishing a similarly enduring and sustaining “home” where the complex relationships needed are nurtured. Existing organizational relationships in Canada, while they have accomplished a great deal, have not proven to be up to the task of ensuring rural Canadians have adequate access to needed services. Therefore it would be naïve to think that we do not need to use our collective imaginations to “purpose build” a venue and process to do so. This clearly must include all of the relevant stakeholders if it is to succeed. One conceptualization of these stakeholders is described by the “Partnership Pentagram” outlined by the WHO in their publication on **social accountability** (professional organizations, communities, the academy, health managers and policy makers). The task for today is to brainstorm on what this might look like and to identify the immediate next steps—to answer the question:

### **WHO Will Do WHAT by WHEN?**

- 1) The General Council of the SRPC has already accepted the concept of a Rural Surgery and Obstetrical Operative Delivery Working Group.
- 2) What should be the mission of such a working group?
- 3) How do we develop the terms of reference for such a working group?
- 4) What should be the composition of the working group?
- 5) What is its accountability and where might it be situated?
- 6) How should the working group be funded?