



CANADIAN ASSOCIATION OF GENERAL SURGEONS L'ASSOCIATION CANADIENNE DES CHIRURGIENS GÉNÉRAUX

CAGS Current Position on the Delivery of General Surgical Services in Rural and Remote Communities in Canada

80% of Canadian live in urban centres. The large distances and not infrequent inclement weather are our reality. Access to universal, high-quality health care is a Canadian right, but the small populations that dwell in places such as High Prairie AB, 2,600, Peace River AB 4,252, Mackenzie BC 3,507 or Fort Nelson BC 3,902 (2011 population data) mean that low event rates make the delivery of full health services impossible. Even though low volume outcomes may not be as good as in high volume settings, when patients are asked, many will accept increased risks in favour in being cared for closer to home.

The Rural/Remote General Surgical service delivery debate has raged for 40 years. The view on one side is that only those with a minimum of 60 months of training in an accredited General Surgery training program should be permitted to perform General Surgery. On the other side of the debate, community needs have seen the evolution of GP surgeons (anesthetists, obstetricians) not just in Canada, but countries like Australia who deliver a narrow range of services safely and competently.

Over the years many solutions have been proposed, ranging from enhanced locum services, return of service contracts, rural General Surgery training schemes for surgery residents and enhanced GP training programs. Across the country different solutions are favoured. In BC and Alberta, enhanced, monitored, mentored and networked training and service delivery is actively being explored. In Ontario a formalized and structured locum service is preferred, while in eastern Canada, fellowship-trained Surgeons acquire community-specific skills.

CAGS' current position is:

1. Patient safety is paramount.
2. Excellence in surgical care is demanded.
3. A "one size fits all" is unlikely to work in a country as diverse as Canada. Therefore multiple solutions are required.
4. International examples show us that physicians, properly trained, mentored, monitored and networked in nationally accredited programs can have the potential to deliver safe and effective surgical care.
5. The "basket" of accredited procedures is limited and controlled.
6. Up-skilled GP surgeons are not considered to have a "mini" FRCS.
7. Modern communication technology in the form of web cams, video conferencing, (surgical) suites, robots (see Saskatchewan - Professor Mendez) can allow for real-time patient management and should certainly be in place before allowing, for example, laparoscopic appendectomy in a remote community.
8. Patient and procedure audit is mandatory to adequately track and demonstrate safety.
9. It is accepted that the event rate for procedures and their complications will inevitably be so low that meaningful interpretation may be difficult.
10. An annual review and recertification need to be formally in place for success.

**CAGS Executive
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