Sustaining rural maternity and surgical care

Lessons learned

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The slow and steady erosion of rural maternity and surgical services over the past 2 decades has been met with a determined push back from care providers, administrators, and those living in rural areas, underscored by efforts to create an evidence base to inform policy and planning.[1] The loss of rural maternity care programs in particular has resonated deeply with stakeholders and has attracted a substantial body of research and policy initiatives. Regardless, beyond stimulating meaningful interest and understanding of these maternity care issues, these research and public policy efforts do not appear to have reversed, or even stemmed, the service closures. The recent "Joint Position Paper on Rural Surgery and Operative Delivery"[2] represents some original thinking on these matters, based on an appreciation of the mutual dependence between the rural surgery and maternity care programs. The physician stakeholders are offering both a window through which to better understand the rural health care infrastructure and a reset opportunity—an opportunity to redirect the research and public policy issues around family physicians with enhanced surgical skills (FPESSs) going forward.

Consensus on close to home

Rural maternity care has led the way for interprofessional consensus through a series of national joint position papers, meetings, symposia, and research programs yielding evidence to underscore rural policy and planning. Multistakeholder policy papers have responded to evidence on the safety of rural maternity care and the attendant need to keep birth as close to home as possible.[3,4]

The consensus on the imperative for care closer to home was endorsed and supported by the efforts of 3 communities, each strategically important to the emerging policies and programs. First, the medical schools responded with knowledge translation continuing medical education activities, training programs to teach cesarean section skills, and rural obstetric nursing programs. Second, several ministries of health responded by endorsing care closer to home as a policy goal. Finally, the research community, supported by the early efforts of the Canadian Institutes of Health Research (2010 to 2011 and 2011 to 2012 operating grants), investigated the safety, outcomes, sustainability, and costs of, as well as satisfaction with, rural maternity care.

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Impasse on safety

In the 1990s, commensurate with the collaborative efforts around maternity care, there was a shared appreciation by both general surgeons and rural FPESSs of a crisis in rural surgical care. However, there was considerable disagreement about the appropriateness of the small-volume rural surgical programs.[5] The case for these programs and for the attendant training of FPESSs was made in the literature, in policy forums, and to the medical schools. The case for restricting surgical practice to specialist surgeons in larger centres was made in the same forums.[6-9]

Substantial efforts at reconciliation of these divergent beliefs were made by both sides.[7,10] The evidence base on the demographic characteristics of FPESSs, the work force, and the safety of these programs emerged in the peer-reviewed literature. Regardless, this impasse seemed irreconcilable, rooted as it was in key philosophical stances of general surgery, namely that the surgical skill set is not divisible (ie, individual procedures could not be learned in isolation); that surgical challenges and complications are unpredictable, rendering assurances of safety by non-specialists inadequate; and that these safety issues supersede any anticipated benefits of local surgical programs.

Operative delivery

The public policy efforts directed at maternity care for the past 2 decades fully appreciate the importance of local cesarean section services. When rural surgical services have closed, the closures have usually been accompanied by efforts to sustain a stand-alone cesarean section service. These have almost always failed. It does not appear realistic to keep the nursing, anesthesia, and surgical staff interested and available where the only procedure done is the occasional cesarean section. Unless operative delivery and, by association, rural maternity care programs can be nested in a robust local surgical program, they have proved to be unsustainable.[1] This recognition of the links between operative delivery and rural surgery programs based on observed outcomes of the natural experiment of service closure

in rural Canada has been pivotal in bridging the gulf between the FPESSs and their specialist colleagues.

Other important factors have contributed to this new consensus on the appropriateness and benefits of small-volume rural surgery programs. First, the formalization of training programs with a commitment to curriculum, evaluation, credentialing, and accreditation within the College of Family Physicians of Canada has moved enhanced surgical skills training from a historical model of ad hoc shoulder-to-shoulder training to a program commensurate with other educational programs.[11] Second, the evolution of general surgery training programs in Canada has not included cesarean section. Currently, the FPESS work force provides an important share of these operative delivery services, even in the larger rural programs with a full complement of specialist staff. The incidental opportunities for collegial support in rural settings have nurtured interprofessional trust and respect. Likewise, the increasing use of urban specialist surgeons to provide itinerant services to the small rural programs has stimulated integration between at least some urban and rural programs. Third, the push back by generalism against the trend to increasing subspecialization[12] has created new alliances based on common experience between 2 of the prototype generalist physician disciplines, namely general surgery and FPESSs. Fourth, there is an increased awareness of the benefits, beyond equitable access, of the small-volume rural programs—trained local surgical first responders, a high level of local medical competence, and an increased capacity to recruit and retain a health care work force. Finally, the attrition of many small surgical programs, often situated very close to regional centres, has eliminated many, if not most, of the specific irritants originally perceived by the specialist surgeons.

Lessons learned

The past 2 decades have been instructive in teasing out some of the larger themes. The interdependency of anesthesia, maternity care, and surgery is stronger and more complicated than was initially recognized. In particular, while players appreciated the dependence of sustainable local maternity care on the availability of local cesarean section services, there was no appreciation of how important it was that the cesarean services be nested in a robust local surgery program.

Owing to the visibility of the early position papers, many of the programs staffed by provincial ministries of health were directed at rural maternity care. By contrast, both historically and contemporarily, there are virtually no ministry programs directed at rural surgical programs. Because of the interdependence between the two, many of the maternity care efforts have had only a marginal effect.

The importance of research, and the evidence it adds to these debates, cannot be overstated. The accumulated database successively documents the desirability, safety, and appropriateness of some surgery and maternity care close to home, and has anchored the efforts over 2 decades that have culminated in this joint position paper.[2] Additionally, there does not seem to be any doubt that collaboration with the international community, namely Australia, produced synergies and offered an expanded landscape—one where both methodology and results could be verified.

It is our observation that the research process itself might have played a dynamic role beyond the actual conclusions drawn. The presence of research teams interacting with professional stakeholders, policy makers, and target constituencies, asking questions and drawing attention to the broader issues might by itself have moved the goalposts. It seems clear to us that rural maternity care in particular benefited greatly from this dynamic.

Finally, where new beachheads of consensus were reached along this journey, there existed a considerable disconnect between the consensus reached among the leadership of the disciplines and their members, especially in the community hospitals. There are still lessons to be learned about knowledge translation.

Current opportunity

The shifting ground under contemporary experiences of health services can provide either blurred vision or cracks through which ways to meet the maternity and surgical needs of those living in rural areas can be seen. The latter opportunity, spurred on by the impending crisis in many small communities across Canada, has won out and led to a common vision between the professions represented through this joint position paper on rural maternity and surgical care.[2] However, beyond the unprecedented collaborative commitment of the care providers involved is the current political alignment of all partners necessary for health system change: policy makers, local administrators, health professionals, academics, and communities.[3] These partners enable responsive policy to be implemented and lines of accountability to be maintained in each essential jurisdiction on the local, regional, provincial, and national levels. Fundamental to these alignments and relationships is the output of optimal patient care underscored by satisfaction within a cost-effective framework.

However, the organizational structure of the partners provides only a framework for front-line provision of care, and it is these relationships that require attention as we move forward with new models of collaboration. To this end, coinciding with the joint position paper is a jointly funded study (Society of Rural Physicians of Canada, Saskatchewan Medical Association, the Alberta Rural Physician Action Plan, and the Rural Coordination Centre of BC) on specialist obstetrician-gynecologist and general surgeon perspectives on FPESSs. Rigorously documenting these voices will

provide further direction for ways to strengthen the path forward for collaborative rural innovation.

This organizational mechanism has demonstrated efficacy in other jurisdictions. It is a networked model in which formal referral patterns between "hubs" and "spokes"[13] are entrenched, creating a sense of regional ownership of outcomes and the attendant drive for educational programs, monitoring, and quality improvement.[14,15] In this way, professional capacity, confidence, and competence might be built and maintained in rural settings.

Although the endorsement of the interprofessional way forward expressed in this paper provides the cornerstone of change, the utility of the joint position paper will depend on the larger web of rural-referral, generalist-specialist, shoulder-to-shoulder relationships and how the ideas are translated into practice at a local level. Although these relationships are certain to vary by provider and jurisdiction, the anchor of a national strategy gives rise to more optimism than we have seen in the past.

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