



**Society of Rural Physicians of Canada
Société de la médecine rurale du Canada**

Media Release

Rural Doctors Applaud Decision to Keep Obstetrics

PARRSBORO, NS April 3, 2002 - Dr Peter Hutten-Czapski, president of the Society of Rural Physicians of Canada applauds civic leaders in Queens who decided to keep Liverpool Obstetrics open. "Keeping the unit open ensures continued high quality care for the community. Letting maternity care go is the first step of turning the hospital into a nursing home." Being able to keep up the skills to attend births means that there is a cadre of doctors and nurses committed and available to deal with many potential complications any time of the day or night. This same team keeps the OR and intensive care areas of the hospital in a constant state of readiness.

Dr David Howe of Parrsboro, says "We advise our pregnant women not to travel, but that's what the system is forcing them to do." The irony is that closing maternity services, while cutting jobs locally, doesn't save money unless people in town stop becoming pregnant. In fact costs rise due to increased ambulance calls and potential complications en route to the further hospital. He adds "If there is enough volume and interest in keeping the service going why close it down?"

Dr Hutten-Czapski left his previous town when they closed obstetrics for a town where he could continue to practice those skills. Doctors and nurses are some of the few that bring money into a rural community from outside. Firing nurses and chasing away doctors affects the financial viability of the local economy.

The Queens municipal council decided to give \$240,000 to keep the Obstetrical services going after announcement of budget cuts that would have forced a closure.

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Backgrounder

About the Society of Rural Physicians of Canada

The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. Founded in 1992, the SRPC's mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities.

On behalf of its members and the Canadian public, SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.

The SRPC is a voluntary professional organization representing over 1,300 of Canada's rural physicians and comprising 5 regional divisions spanning the country

Health care centralization risks safe maternity care and community sustainability

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Under budgetary strains, regional health authorities are looking to cut costs by restructuring and consolidating services. At first blush, centralizing services may make sense, as it is claimed that larger units function more efficiently. But when centralization occurs without a full appreciation for the consequences to the life of rural and small urban communities, serious unintended effects can result. Cost savings may prove elusive, as the decision to close hospitals in smaller communities carries with it health and economic risks.

The case of rural maternity care offers a telling example.

While many health services are at risk, maternity care is particularly vulnerable to the negative effects of centralization. Most physicians who practice in rural areas do so because they are drawn to the variety and scope of practice and have a commitment to community as a core value. Working with local colleagues, they can turn for back-up to those with surgical and anesthetic skills when confronted with problem births. And there is a synergy between general and specialist physicians, nursing and regulated midwifery. Each profession is key to an adequate and safe maternity service. (1-7)

Most importantly, the false economy of centralization is revealed when women have to leave their communities to travel large distances to seek services. It is much more than an inconvenience for them and their families.(8-9) The loss of maternity services releases a cascade of adverse consequences for mothers and babies:

1. Physicians and nurses stop doing maternity care or provide only a limited service.
2. Women from less central communities must travel, often at great expense in financial and personal

terms, ultimately to be cared for in a distant center by persons unknown.

3. The community becomes what is known as a "high outflow community" 8-9) in which, research shows us, the frequency of small premature infants goes up, as does maternal and newborn complications--even though the women (most but not all) have traveled to a good place to be delivered by good people.(8-11)This is due to a lack of support from family and friends, delays in transfer and other complex issues.
4. These complications dramatically escalate health care costs.
5. Midwifery practice in such communities is made impossible, as midwives need physician and institutional backup to practice.
6. Physicians and nurses become even less satisfied with their work and less committed to their communities. (12-13)
7. Other aspects of women's health care, such as prevention, counseling and office gynecology, begin to atrophy.
8. Many of the remaining physicians, suffering under impossible on-call schedules and isolation, retire or relocate.(14-16)
9. The community finds it even harder to attract and replace physicians and maternity-skilled nurses.
10. Physicians, nurses and the community itself suffer the loss of an entire skill-set related to reproductive and women's health.
11. Student physicians and nurses, seeing discouraged teachers, choose not to enter this field of practice, selecting settings with less on-call and less stress. This further restricts women's access to high quality maternity care.
12. But it is not just about maternity care. Ultimately ER, surgery and anesthetic services in some rural communities collapse because the number of physicians required to sustain on-call coverage no longer exists.
13. Businesses find it difficult to recruit employees to communities where medical services are limited. (18-19)
14. Many residents of the community (especially those in their reproductive years) begin to wonder why they are living in the community and try to move (many can't).
15. The community itself becomes dysfunctional and unstable. Maternity and newborn care is realized too late as being a lynch pin for sustainable communities, medically, socially and economically.

This negative cascade of events is an example of a process that occurs in other fields as well. We could equally talk of general surgery, rehabilitation, mental health services, general pediatric bed loss in small community hospitals and other interdependent services, but the loss of maternity/newborn services offers one of the clearest examples of the consequences of poorly planned centralization.

All levels of government need to consider seriously the unintended "costs" of centralization and resist the urge to consolidate services solely for apparent short-term economic reasons. We need to be alert to the interdependence of a series of skills to the life of a community, and we need to support maternity care providers in rural and urban settings so that they can continue to care for a precious resource, the women and children of our society. (19)

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