

Preface

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“The modest country doctor may furnish you the vital link in your chain, and the simple rural practitioner is often a very wise man.”

- Thayer, W. S., “Osler, the Teacher,”
Johns Hopkins Hospital Bulletin, 30:198, 1919.

“A rural doctor is someone chewing more than can be bitten off”

- anonymous, possibly from ancient Mesopotamia

A Manual of widely varying rural medical procedures, such as burr holes, casting, breech deliveries, skin grafts and so on, springs from needs specific to rural life. Rural populations are older, sicker, poorer and more prone to accidents than their urban counterparts, no matter what part of the world they live in. The generic challenges of health care delivery to rural populations are identical whether it's in Nepal or Ghana, Canada or Australia - widely dispersed patients, a dearth of specialists, and, as urban centres aspirate most funding, chronically meager budgets for the job on hand.

Transport of patients to urban centres has been one of the answers to counter these challenges, but, in the absence of expensive all-weather dedicated transport crews, this solution is limited. Information technology is a newer solution holding promise in certain cases, but not at the expense of degrading local capabilities.

The Rural Generalist

In the end, wherever rural health care is practised, the best delivery model has always been a local team of broadly skilled generalists suitably supported and functioning as a closely-knit unit. The members of this historically proven model work on the primary, secondary and sometimes tertiary levels of care, constantly fluctuating among levels. Generalism, defined as the partial practice of one or several disciplines, is the necessary operating principle. This jack-of-all trades approach, mirroring the entire rural work force, is required not just among physicians but also with nurses, social workers, physiotherapists and all other health workers, right down to the hospital janitor. The hallmark of a generalist is one or several “limited skill sets” or “defined procedural competencies”, defined by the community's needs, outlined and legitimized by consensus at various levels of the system, with outcomes and quality identical to those same skills carried out by specialists.

The local generalist model of health care delivery is faltering in this world of increasing differentiation and specialization, especially so in western, so-called

“developed” nations. And yet, two characteristics that define the entire rural workforce anywhere in the world are the generalist nature of the work and the imperative to respond to the needs of the local population. Why should the medical workforce be any different? Cassandra was condemned to continually predict disasters, always being accurate, but with nobody ever believing her. A rural health care Cassandra would hold that if the forces of medical specialization are left unchecked, our Canadian rural populations soon will have little, or no, local access to even the most basic of secondary care.

The Society of Rural Physicians of Canada

The Society of Rural Physicians of Canada (SRPC) was founded in 1993 from two complementary sources. The first was the need for political and policy support, both for the working conditions of Canada’s rural physicians and the right of our rural communities to equitable health and health care. The second impetus was the unmet need for rurally relevant medical education, both for trainees and for continuing medical education of established rural physicians.

The SRPC has made quick progress over the last years, particularly when one considers that Canada’s health care delivery system is the political responsibility of its 13 separate provinces and territories. This results in quite a hodge-podge of policies, none meshing very well. In close participation with the SRPC, the College of Family Physicians of Canada, our national accrediting body for post-graduate family medicine training, brought out a rural curriculum – a step towards offering alternatives to “learned helplessness” and instead promoting “clinical courage”. The Canadian Medical Association, again with the help of the SRPC, has issued a national rural health policy paper that, if not implemented, is at least ready with some solutions. Many faculties of medicine in Canada have incorporated SRPC suggestions in responding to government decrees (again SRPC promoted) that medical students and residents spend significant time training in rural Canada. Many SRPC members now work prominently in our universities. Federally, where support for generalism is likely to be funded, the SRPC has been, and will continue to be, heard and quoted in a wide variety of influential circles.

We have seen a recent surge in much-needed rural research, partly because of SRPC prodding. A whole lot more research is needed – one effect is local pride and validation of practice – but it is gratifying to see the interest now being generated in the health of Canada’s rural populations. Further research can only help attract fairer funding.

We can be very proud of the SRPC’s efforts to characterize and support the three pillars of rural health care – maternity care, anesthesia and surgery. Policy papers, often written jointly with our specialty organizations, and some key joint committees, now form a good foundation for future reinforcement of these key rural services.

Arguably the most lasting impact the SRPC has made has been in the educational field. The SRPC Annual Conferences on Rural and Remote Area Health have been “group psychotherapy masquerading as continuing medical education”, plus much more. Practitioners from all walks of rural practice have been able to find relevant and practical education, more often than not delivered by peers, while feeling that they have “come home” to be with others of similar experiences. RuralMed, the SRPC’s Internet discussion board is another example of a very actively used communication and support tool. The Rural News, and lately the Rural Road (in association with the Rural Doctors Association of Australia) are further examples of keeping the rural doctor informed and supported, this time in print. Lastly, the Canadian Journal of Rural Medicine, having passed the National Library of Medicine’s difficult criteria to be listed in the Index Medicus and Medline, shines as the SRPC flagship. Unique in the world of scholarly publications, the CJRM offers a panoply of peer-reviewed research articles, practical how-to segments, humour, policy, analysis, entertainment and just plain old rural vision for all comers.

Manual of Rural Practice

Which brings us to this SRPC textbook on rural procedural medicine. The need is obvious and the publishers and editors are to be thanked. Drawn from the “Occasional” series in past issues of the CJRM, all the sections have been reviewed, revised, illustrated and spruced up, with new chapters commissioned and brought up to date for 2006/2007. In these chapters you will find many procedures required in rural medical practice; either to be learned for the first time or to be refreshed. A glance at the index will show numerous skills as diverse as rural medicine itself. Since each rural community is different from the next, not all of the Manual’s sections will apply to any one area, but there is much in this textbook for everyone.

The word “occasional” in these pages reflects the realities of generalist rural practice, where the need to do certain procedures arises acutely if infrequently. Unlike some medical procedures, those discussed in these pages can all be done competently without any minimum yearly number to maintain proficiency. Depending on the learner’s previous experience and personality, the skills can be acquired either right from these pages, or with some minor, supervised reinforcement or “shoulder to shoulder” training.

Introducing some of these procedures to a hospital without nursing or administrative support can be more difficult than learning how to do them. Having easy access to supplies and the backing of your nursing staff can make all the difference to whether the service is available to your rural populations. This textbook also tells you where to go for ordering supplies and implementing protocols. What could be more practical than that?

A tip of the hat and a tug of the forelock to the hard working, inspired compilers, editors and publishers of this unique textbook.

Carry on, rural physicians. Keep the generalist lamp burning, confident you are continuing the work of centuries of careful medical practice, endorsed by the giants of the medical world. Develop and maintain your defined procedural competencies. Use this excellent manual as much as possible – you might need four copies – for the ER, surgery, delivery room and in your car. And always remember an old SRPC motto. “You’re the best in the country.”