2. GP Surgery within Regionalized Health Care

Jude Kornelsen

Overview
Data supporting the RBI presentation suggested that some communities may require significantly higher levels of services based on population, vulnerability, and degree of isolation. With the goal of making spending and allocation of services more efficient, health care reform in the 1990s led to the concentration of services in regional centres motivated by the goal of fiscal constraint. This strategy, however, has led to diminished access to primary care in small rural surgical units because of high outflow to regional centres. Dr Kornelsen’s presentation considered the question, what is the appropriate allocation of services between small/medium-sized rural surgical units and regional centres? With that knowledge, how can we improve access to local care in small rural communities?

Power Point Presentation

**GP Surgery within Regionalized Health Care**
What does the interface between small/medium-sized rural surgical units and regional centres look like?

**The Imperative to Centralize Services in Regional Hospitals**
- The 1990s was marked by health care reform across Canada to address:
  - Rise in public expectations
  - Restraint or retrenchment of health spending
  - Increasing costs of care
  - Proliferation of new and expensive technologies

- Characteristics include:
  - Efficiencies of expenses
  - Focus and valuations of specialized services for a region
  - Intermediary governance structures (Health Authorities) responsible for decision-making/planning
  - Aims for better distribution of financial resources
Regional Centre

Community Hospital

Population: 28,000
Population: 10,000
Population: 12,000
Population: 10,000
Population: 15,000
Population: 9,000
Total Catchment: 84,000

Characterized by specialist services

Community Hospitals:

- Obstetricians
- General Surgeons
- Orthopedic surgeons
- Psychiatrists
- Urologists
- Radiologists
- Pathologists

What is ‘primary care’?
- Prevention and treatment of common diseases and injuries
- Basic emergency services
- Referrals to/coordination with other levels of care (such as hospitals and specialist care)
- Primary mental health care
- Palliative and end-of-life care
- Health promotion
- Healthy child development
- Primary maternity care
- Rehabilitation services

Health Canada, ‘About Primary Health Care’
http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos/index_e.html

Rethinking ‘Primary Care’ terminology
- ‘Primary care’ is an urban concept that assumes one location/multiple levels of providers
- Does not account for geographic realities that limit access to specialist care
- Does not acknowledge the advanced procedural care that may be necessary to facilitate primary care (e.g., access to cesarean sections to support all birthing women)

Key Questions
- What are the human resource effects of the decision to create a regional centre?
- What are the fiscal implications of regionalization?
- What are the effects of regionalization on communities (regional and outlying)?
- How does GP Surgery fit within a regionalized health care structure?
Discussion:

The importance of considering the community and the differences between individual rural surgical programs emerged in the discussion following the presentations. Some of the topics that participants discussed were:

Community voice
- What level of health service do patients want in their communities?
- Why do patients choose to stay in their home communities or go to referral centres for care?
- How do practitioners help patients to consider changing their referral patterns?

Community support
- GP Surgery does not exist by accident; it is based on determined personalities, but it is not systemized.
- Do we know of countries that have developed a system of GP Surgery that addresses the needs of communities and simultaneously respects the skills of generalists? Are there other jurisdictions that we can use as models? South Africa, for instance?

Community choice
- How much free choice or planning do we want to establish in the system?
- We want to create a model that respects patient choice, not a system that is restrictive and tells people who they need to see and where.
- We need to discriminate between descriptive and prescriptive models.

Community individuals
- The relationships in place between GP Surgeons and referral hospitals are key because in those communities where the relationship works, it is due to the will and effort of individuals.
- When developing models, we need to be flexible to allow individuals and communities to make it work of their own volition. The system cannot be too rigid.

Community in perspective
- We need to consider the many levels needed to build a model of GP Surgery: individual, geographic, community, bureaucratic. There may not be only one model to encompass the different levels.
III. How Do We Get There

1. Proposal for a Training Program for Rural Family Physicians in Surgery
   Nadine Caron and Nancy Humber

Overview
Drs Caron and Humber outlined a proposed program initiative to create a formal accredited training program in Rural Surgery for Family Physicians at UBC. Dr Caron began with a review of the GP Surgeons Project (Rural Maternity Care Research NET), highlighting the issues of greatest pertinence to GP Surgeons in BC: importance of mentorship, appropriate training environments, barriers to credentials and privileges, lack of continuing medical education (CME), and lack of professional support. A new program in GP Surgery would address these needs and barriers and work in collaboration with different university departments and specialists to provide graduates with a well-rounded surgical technique and decision-making education. In detail, the program elements would be based on current training models in other countries and in GP Anesthesia, and a proposed training site was Prince George and rural satellite communities. Dr Humber outlined the curriculum of the GP Surgery program, emphasizing the rural focus of the training, and detailed the components of certification.

Power Point Presentation

Proposal for a Training Program for Rural Family Physicians in Surgery
• Ad hoc Committee
  - Family Medicine
    - R Woolard, P Newbery, Nancy Humber, S Iglesias, J Kornelsen
    - Surgery
    - E Webber, N Caron

Interviews with GP Surgeons
(what they told us)
• Importance of mentorship
• Training environment w/o surgical residents
• Hostile training environments
• Difficulties with privileging / credentialing with a skill set that isn’t portable
• Lack of CME
• No professional support

Principles of a New Program
• Training is located in a formal accredited postgraduate program within the Department of Family Medicine with collaboration from the Departments of Surgery and Obstetrics/Gynecology

Principles of a New Program
• Graduates receive a certificate from Family Medicine attesting to their successful completion of the program (model is the GPA program)
• Certificate will be signed by representatives from all 3 Departments (Family Med, Surgery, OB/GYN)
Principles of a New Program

- Curriculum includes the historical rural skill set as well as newer diagnostic and screening procedures, particularly endoscopy, which have been shown to be appropriate for Family Physicians.

- Curriculum should support a wide scope of practice, including those procedures known to be safe and appropriate for the level of GPS training.

- Curriculum development recognizes the association between scope of practice and volumes in the rural surgery programs.

- Core skill set with options for additional skills.

Program Elements

- Models
  - Grande Prairie - GPS
  - GP Anesthesia
  - Australian Rural Surgery Program

- To be determined
  - 12 months?
  - 6 month Surgery / 6 month OB
  - Prince George (T), plus satellite rural centres
    - sufficient volume
    - w/o senior surgery residents
  - 2 trainees per year (maximum)

Curriculum

- Goal: a broad scope of practice that includes
  1) emergent procedures
  2) common elective procedures
  3) screening and diagnostic procedures

- Suggested but also supported by research and statistics known to date.
LEARNING OBJECTIVES

- Communication and applied knowledge

LEGAL DIMENSIONS

CONTENT

- Basic Surgical Skills
- The Management Process – Surgical Conditions
- Operative Procedures

APPENDIX C

- WOUNDS
  - Appendectomy
  - Herniorrhaphy
  - Breast Biopsy
  - Perianal Surgery
  - Dorsal Suturing

APPENDIX C

- Other Surgical Specialties
  - Carpal Tunnel Release
  - Wedge Resection
  - Extensor Tendon
  - Revision Digit Amputations
  - Ganglionectomy
  - Vasectomy

APPENDIX C

- Endoscopy
Evaluation
- Continuous throughout program - formal and informal
- Consistent with:
  - CFPC (4 principles of Family Practice)
  - RCPSC (CANMEDS)

Certification
- Model is GP Anesthesia
- Documentation that the trainee has successfully completed the GP Surgery Program in Family Medicine, UBC
- Program is accredited by the CFPC
- All 3 Departments involved (FP, Surgery, OB/GYN)

Post Grad CME
- GP Sx ("day" once yearly (model: Dr Bolton's GP A "day")
- Spend a day in the urban OR
- Return to training sites prn for refresher/volumes
- Education AND networking with other GPS and specialists supporting GPS (especially those they originally trained with)

Post Grad CQI
- Log books
- Regional M&M rounds
- Provincial database - surgeons and cases
- Audits and research
Discussion:

Different suggestions were put forth by the participants to improve the design and implementation of a GP Surgery training program. The “workshopping” discussion covered the following topics:

Training models
- We should draw on the experiences of the Oregon Health Sciences program in general surgery; use their model of training in a “mother house.”
- The Pacific Northwest WAMI program, a distributed program, can also be considered. American College of General Surgery has curricula we should be consistent with.
- We can look to the GP Anesthesia program and use it as a model to see whether it is working for trainees.

Mentorship
- Supportive mentors underscore successful training. In GP Anesthesia training, the candidates must spend at least 6 months in a community with a GP Anesthetist.
- Rural surgical training is an iterative process, requiring ongoing, collegial support.

Location
- The education site needs to be carefully selected. The program will need to match trainees with communities that need GP Surgeons.
- Trainees may experience frustration in communities lacking infrastructural resources for a surgical program. How do small communities acquire the infrastructure to sustain rural surgical programs?

Budget
- Nursing is the primary budgetary challenge (e.g., the availability of OR nurses).
- Program availability is not based on the skill set of practitioners, but is dictated by available resources.

Sustainability
- Without a local surgical program, sustainability of medical services is difficult.
- The volume of services is also important – volume dictates scope of practice.

Community support
- The community is key in helping acquire new equipment.
- With the concentration of newer technologies in regional centres, older equipment is being handed down to smaller centres (e.g., Lillooet).
- It will require the support of individuals from many levels to establish a GP Surgery system that will work.

Communication
- Examples of strained communication between patients in satellite communities and surgeons in referral communities were noted.
- Participants acknowledged the positive contribution GPS make. Proximity to patients creates continuity of care.

**Recruitment and Retention**
- The lifestyle of practitioners and the need for resources in the community (e.g. schools) needs consideration.
- We also need to pay physicians the appropriate amount to entice them to work in a rural community and stay.
- The Rural Education Activities Program (REAP) can fund rural physician training and may augment the surgical resident’s salary.

**Curriculum**
- The program needs to address core skills that can be transported, but also needs to give an opportunity for individuals to get additional training in skills that will meet specific community needs.
- We need to be flexible about how we train people so that skills are community-specific.
- Core teachings should cover surgical knowledge of physiology, pathology, procedures, and enhanced skills.

**Public Awareness**
- Do medical students know that GP Surgery exists? Many recruits go back into rural communities, learn of the need, and then go back for additional training.
- An existing program may draw more attention to rural surgery and attract young medical students, especially those who do not yet have families and commitments.

At the conclusion of the discussion, before breaking for lunch, Garth Warnock, Head of the UBC Department of Surgery and Editor of the Canadian Journal of Surgery, offered his support for publishing a consensus paper in the journal. He also suggested that the group present at the annual meeting of the British Columbia Surgical Society.
2. A Support Program for Small Volume Rural Surgery Programs  
   Stuart Iglesias

Overview
All British Columbia hospitals today are struggling with a lack of health human resources. For rural communities in particular, the struggles of local surgical programs are compounded by challenges in recruitment and retention of physicians and nurses. One model support program is the United Church Health Services, which provides not only financial but also moral support for its practitioners and nurses through site visits, problem solving, and advocacy at both a local and Health Authority level. Dr Iglesias proposed a similar structure for the GP Surgery training program, providing trainees with a ‘point person,’ a Rural Surgical Program Director, and a supportive academic ‘home’ within the Department of Family Practice. Educational benefits offered by the program could extend to other care providers as well in the form of inter- and intra-professional training of rural surgical teams (nurses and physicians).

Power Point Presentation

A Support Program for Small Volume Rural Surgery Programs

Rural Surgery Support Program
- Model is the UCHS (Bella Bella, Bella Coola, Hazelton)
- Support for local physicians and their programs

Rural Surgery Support Program
Why??
- Small isolated programs with common problems
- All have sustainability issues
- Each plays an important role in local health care

Rural Surgery Support Program
Why??
- Health Human Resource Issues
  - Recruitment and retention
  - Credentialing/Privileging
  - Locums
  - Continuing professional development
Rural Surgery Support Program

Why??

- Training
  - appropriate training sites
  - fostering relationships with referral centres
  - development/support for a new GPS training program
  - upgrading/refresher programs

- Continuing Professional Development
  - CME for professional staff
    - courses
    - visits to urban OR’s
    - mentorships

- Continuing Quality Improvement
  - database (log books, registry)
  - regional M&M Rounds
  - audit and research

- Advocacy
  - “It isn’t that anyone is trying to end rural surgery services, it’s that no one is trying to save them.” Society of Rural Physicians of Canada

Resources

- Staffing
  - one full time position
  - physician?

- Financial
  - admin support
  - travel
  - locum support
  - CME
  - audit and research

UBC Family Medicine

Health Authorities

BCMA - Rural Coordinating Centre

When??

5-10 years ago
Discussion:

During the discussion, participants articulated the university’s role and the responsibilities of the program director and instructors:

University’s role
- The program would be housed under the UBC Faculty of Medicine which would support the Departments of OB/GYN, Surgery, and Family Practice to aid the Program Director of the Family Practice Surgery Program.

Program Director
- This director would be the program’s point person providing guidance to training-site directors and Most Responsible Persons and mentors from General Surgery, OB/GYN, and Family Practice.
- The program director would be responsible for finding locations and rotations, and liaising with the postgraduate medical office.

Instructors
- There is a general sense of ‘teaching fatigue’ in Prince George and concerns that GPS residents would not get the experience needed if they were learning alongside General Surgery (GS) residents. A solution may be to alternate between GS and GPS residents throughout the year.
Discussion: Articulating a Research Agenda

One of the challenges facing the growth and evolution of GPS in British Columbia is the lack of an evidence base from which to make decisions. All participants recognized the importance of continued research in parallel to program implementation and articulated the following main thematic research areas. An extended list of research questions can be found in the Appendix 2.

What kind of evidence do Health Authorities and decision makers need?

- Measure costs and outcomes.
- Review the decision-making process and assess its deficits.
- Broaden the agenda of what we need to know in order to make decision making as evidence-based as possible.
- Analyze and measure the process and consequences of the decision making of policy makers in order to show them the results of their decisions (i.e. financial, social, etc.).
- Explore the barriers between the groups involved – Obstetrician-Gynecologists, General Surgeons, GP Surgeons – in order to see where each group stands and how we can move forward in consensus.

What are the most important factors in allocating services in small rural hospitals? Is the most important factor budget allocation?

- Not every site can provide local surgical care, so we need to know what care providers are capable of and what they do best.
- We need to find incentives for keeping and maintaining resources (i.e. salaried physicians).
- Safety, financial, and efficiency concerns are the three main items of consideration from the Northern Health Authority.
- In Sechelt, the community took matters into its own hands. They were struggling to recruit a General Surgeon. The community recognized that there might not be a surgical program in the future if they did not acquire a CT scanner. The community realized they had a voice and fundraised to purchase the technological infrastructure.

How important is cost-effectiveness in decision making?

- If rural surgical programs are not cost-effective, and that is the only measure of success, then we should close them down. Just because a program is cost-effective, doesn’t mean that it’s better.
- The issue is having better outcomes while being cost-effective.
- It’s important to consider where the costs are incurred – community level, individual level, regional health authority level.
• Costs are not just monetary. There are political and social costs as well. There are also hidden costs – costs of recruitment and retention, costs of poor health, ambulance transfers.
• There will always be a cost. If the health care system is not paying for it, then the patient is paying for it.

At what size of hospital does quality of care begin to decrease?
• Let’s not assume that regional care is better. We need to conduct a full assessment of regional and smaller centres and study both sides equally.
• The current definition of rural health care is ‘one physician from disaster.’ People are leaving not because of payment but because of limited numbers of team members. One can measure the team’s sustainability according to their critical mass factor. The magic number seems to be 7-10 physicians.

Would different payment models for rural GP’s enhance and maintain rural surgical services?
• Put physicians on salary, because if you want to attract someone to a job, you need to support their lifestyle.
• There needs to be evidence about alternative payment schemes.

Is there a way to investigate what influences retention of a level of service in a rural community?
• Historically things were simpler. When there was a need, somehow the service persevered to meet that need. With regionalization things have changed and now the equilibrium has shifted and we have lost services in some communities.
• The viability of the hospital community is another issue. You need to build a team that will work together; these are the essentials in an immediate community.
• We need to consider measurable variables: make-up of team, mode of payment, quality of care.

What are the barriers to communication among health care administrators?
• Communicating with the health authorities on short and long term consequences is a real challenge.
• It’s good to ask hospital administrators what they need to know to make decisions, but it’s equally important to tell them what they should know to make decisions.

What are the key elements of a sustainable rural surgical program?
• Sustainability is linked to volume and there are three ways to increase volume: scope of services, capture your population (less outflow for services), and providing itinerant care.
• The root to sustainability is ‘more not less.’ We want to have on-going and elective surgery to support a sustainable practice service. We want to support smaller centres
to do as many procedures as possible (always considering quality of care; meet the surgical needs of their community).

- We need Health Authority support and that can be through increased funding for nurses.
- OR nursing is a key part of this. Maybe we could consider training rural surgical teams. The volume issue is linked to sustainability and the importance of interdisciplinary teams.

If we build a surgical training program, is anyone interested? Are there specialist surgeons who are prepared to support it?

- There needs to be a willingness to work together between disciplines to explore common ground.
- The group is going on a ‘road show’ to speak to communities that could be involved and will bring them up to speed on some of the issues and research that have been generated.
- We need to consider professional and program support: vacation relief, CME, reduction of professional isolation.
- We need to provide surgeons with nursing and full staff support in order to create an interdisciplinary collaborative model of team-based care.
- There is a clear need for GP Surgery, but we have traditionally faced challenges in getting our evidence across. If we face obstacles now, that does not mean we should stop.