



### President's message. Babies in the bush

Trina M. Larsen Soles,  
MD

Golden, BC

Correspondence to:  
Dr. Trina Larsen Soles;  
PO Box 1170, Golden, BC;  
tsoles@srpc.ca

Society of Rural  
Physicians of Canada

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rurale du Canada

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**SRPC / SMRC**

Box 893  
Shawville QC J0X 2Y0  
819 647-7054, 877 276-1949  
fax 819 647-2485  
admin@srpc.ca

www.srpc.ca

**M**y community of Golden is experiencing a spring baby boom. We are blessed to be far enough from the nearest centre to have retained our operating room, and lucky to have a pediatrician who likes living here. We can handle most obstetrical challenges and we only transfer women and neonates needing tertiary care. However, statistics show that my community is an exception and the reality of rural maternity care is becoming increasingly challenged.

Fewer family physicians are delivering babies. A higher percentage of rural physicians than urban still do deliveries, but even in communities with obstetrical services it is rare for all physicians to do so. A specific rural threat is closure or downgrading of hospital services that support maternity care. Although studies show better outcomes in communities with obstetrical services but without cesarean section (C-section) capability than in those who transfer out all obstetric cases, fewer physicians are comfortable practising obstetrics without C-section availability. The Canadian birthrate is declining, and gone are the days where one would deliver 200 babies during a rotating internship. All these factors lead to fewer skilled and confident practitioners.

The Society of Rural Physicians of Canada is currently involved in a project led by the Society of Obstetricians and Gynaecologists of Canada on Multidisciplinary Collaborative Primary Maternity Care (MCP2). The Project is funded by Health Canada and is developing models integrating a variety of health care professionals in an attempt to provide sustainable levels of maternity care in Canada. Participants include obstetricians, midwives and family doctors. There is strong political support

for models emphasizing shared care between obstetricians and midwives. However, the role of the family doctor is less clear as fewer FPs choose to practise obstetrics. In rural areas this becomes a significant challenge. We will never have the volume to support specialist obstetricians, and, although some midwives choose rural locations, the low volume of deliveries would not sustain a full-time midwife.

Our concern in the SRPC is that we have different needs from the urban population when it comes to provision of obstetrical care. The majority of rural maternity care will always be provided by rural doctors. We need adequate hospital facilities to enable this care and nurses who are trained and comfortable in providing this care. We need training in advanced skills for rural GPs in obstetrics, anesthesia and surgery.

The SRPC supports the rural collaborative model consisting of rural GPs with enhanced skills working with rural nurses with enhanced skills. The SRPC is represented on the National Steering Committee and subcommittees by Drs. Brian Geller, Jill Konkin and Saskia Acton. Over the next 2 months a number of our members will be interviewed as part of the research arm of the MCP2 Project. There will be a link on our Web site to the project, a survey on RuralMed, an insert in *CJRM*, and a presentation at our national conference in Montréal in April.

The outcome of this Project has the potential to significantly affect our ability to provide obstetrical services in rural Canada because governments will look to the recommendations when deciding what services to fund. I want to thank all the SRPC members who are providing a strong voice for rural maternity care as the Project unfolds.