

# Cairns Consensus Statement on Rural Generalist Medicine

**Improved health for rural communities through  
accessible, high quality health care**

**Representatives of organisations listed below contributed to the development this statement at the *Inaugural World Summit on Rural Generalist Medicine*, held in Cairns, Australia on October 30 2013**

**Australian College of Rural and Remote Medicine  
Australian Indigenous Doctors Association  
College of Family Physicians Canada  
College of Family Physicians Singapore  
European Rural and Isolated Practitioners Association  
Government of Fiji  
Government of Tuvalu  
Government of Vanuatu  
Government of the Cook Islands  
Indigenous Physicians Association of Canada  
James Cook University Australia  
Japan Primary Care Association  
Northern Ontario School of Medicine Canada  
Pasifika Medical Association  
Queensland Health Australia  
Rural Doctors Association of Australia  
Rural Doctors Association of South Africa  
Rural General Practice New Zealand  
Royal New Zealand College of General Practice, Division of  
Rural Hospital Medicine  
Society of Rural Physicians Canada  
University of Washington  
World Organization of Family Doctors (WONCA) Rural  
Working Party**

## **The Health of Rural Communities and Rural Generalist Medicine**

- 1 We, the above-named organisations, resolve to strengthen health care systems in rural\* communities by promoting the practice of Rural

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\* In many countries, the terms rural and remote are used to denote the spectrum of rurality. In this Consensus Statement we use the word 'rural' to encompass both.

Generalist Medicine. Our goal is to improve the health of people living in rural areas through access to effective, safe and affordable health care.

- 2 People living in rural communities typically suffer poorer health status than their urban counterparts. In spite of this, rural communities have less access to health care. Individuals and families living in rural areas are often obliged to travel unreasonable distances to access essential health care, including lifesaving emergency care, maternity care and child health services. They may receive only fragmented care or periodic visiting specialist clinics. These inequities are compounded for indigenous rural communities.
- 3 Rural communities comprise almost half the world's population and a greater proportion in low-income countries. Rural communities produce most of the world's food and natural resources and are entitled to equitable access to safe, effective and affordable health care as close to home as possible.
- 4 The broader social and economic development of rural communities is promoted through the availability of quality local health care, of which Rural Generalist Medicine is an essential component.
- 5 We assert that rural communities require a strong generalist approach to all health professional services and in particular, skilled doctors who can provide a broad scope of clinical care, working in concert with other members of the health care team. That tradition, the tradition of Rural Generalist Medicine, is under threat as a result of trends to medical sub-specialization in cities and a diminished role for generalist doctors as a consequence.

#### **What do we mean by the term 'Rural Generalist Medicine'**

- 6 We define 'Rural Generalist Medicine' as the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:
  - Comprehensive primary care for individuals, families and communities;
  - Hospital in-patient and/or related secondary medical care in the institutional, home or ambulatory setting;
  - Emergency care;
  - Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues;
  - A population health approach that is relevant to the community;
  - Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs.
- 7 The practice of Rural Generalist Medicine is unique in the combination of abilities and aptitude that is required of a doctor for a distinctly

broad scope of practice in a rural context. Rural Generalist Medicine is a concept that is grounded in the needs of rural communities, not on professional 'turf' nor professional craft-group identity or ambition.

- 8 We acknowledge and respect the fact that elements of the scope of Rural Generalist Medicine are shared across a number of professions and medical professional craft groups, including the care that is provided by those General Practitioners or Family Physicians (GPs/FPs) who are trained primarily in community-based primary care roles, hospitalists, emergency physicians, GPs/FPs with special interests as well as a range of consultant medical specialists. All these groups have their contribution to make. Similarly, we recognise that there are still doctors around the world who work to a comparably broad scope of practice in the urban context and this is to be supported.
- 9 We assert that those doctors who are trained and credentialed to practice Rural Generalist Medicine have been, are and always will be, an essential requirement for health service delivery in rural communities. Their services are also likely to be increasingly required in larger population centres.

#### **Why is Rural Generalist Medicine important?**

- 10 We believe that Rural Generalist Medicine is an essential component of health care if rural communities are to be assured of access to comprehensive primary care that is integrated with secondary and tertiary health care services. The strength of Rural Generalist Medicine is the ability to deliver quality, personalised and contextual care across the continuum of health services and from cradle to grave.
- 11 From a rural patient and community perspective, Rural Generalist Medicine has many specific advantages. These include: ready access to skilled, culturally competent and locally-informed practitioners; improved continuity-of-care and follow-up; a better patient experience through familiarity, trust, personal relationships and patient-centred care; stronger integration of visiting consultant specialist services and tele-health; reduced health care costs; and less personal and economic disruption associated with transport to distant services.
- 12 Rural Generalist Medicine can be tailored to available resources and local health care priorities of communities. For indigenous communities and marginalised groups, skilled local doctors practicing Rural Generalist Medicine as part of a team offers the best prospect of assuring effective medical care that is culturally competent and responsive to priority community needs.
- 13 From a health systems perspective, Rural Generalist Medicine has doctors applying a full and evolving skill-set, thereby increasing professional satisfaction, productivity and rural retention. Stable models of team-based care are promoted and there is a reduced reliance on locums. This supports establishment of a quality rural

learning environment for students, doctors-in-training and others. Medico-legal risk and associated costs are reduced.

- 14 While there may be a sufficient overall supply of doctors in some countries, the medical workforce is mal-distributed, being concentrated in urban areas and overly sub-specialised. In areas and particularly low-income countries, these same factors exacerbate overall medical workforce shortages and are compounded by medical migration.
- 15 We assert that simply training more doctors using conventional models in the hope that they might 'trickle-out' to rural communities is a failed strategy. Paradoxically, this approach may lead to further fragmentation and specialization of care, waste scarce health care resources, undermine the practice of Rural Generalist Medicine and team-based models of care and thereby worsen inequities in health care for rural communities.
- 16 Around the world, health systems are under pressure due to unsustainable growth in expenditures, ageing populations, an increasing burden chronic non-communicable disease, unwarranted fragmentation and specialization of care, persistent health inequities and, in many countries, large gaps in medical, nursing and midwifery workforce. Rural Generalist Medicine – and clinical generalism more broadly - offers an important positive contribution to meeting these challenges.

#### **What is action is required to advance Rural Generalist Medicine?**

- 17 We identify the following as key actions in global efforts to meet the health care needs of rural communities by strengthening Rural Generalist Medicine:

##### **A. Recognition of Rural Generalist Medicine as distinct scope of medical practice**

- 18 Within health care systems, Rural Generalist Medicine must be recognised and valued as a distinct scope of medical practice that is essential for effective rural health care. Doctors who are trained and supported to practice Rural Generalist Medicine represent a key component of workforce in a contemporary, technology-enabled and team-based approach to meeting rural health care needs.
- 19 Along with recognition, Rural Generalist Medicine must be enabled through the following actions: appropriate systems of clinical governance (including clinical privileging and credentialing); appropriate remuneration (models and levels); career structures; training models; maintenance of professional standards; investment in local health facilities and infrastructure; provision of family supports and living conditions; in health services and health systems leadership; and in health workforce planning and investment.

##### **B. Training pathways for Rural Generalist Medicine**

- 20 An active pathway of recruitment to and training for a distinct career in Rural Generalist Medicine is required. The training pathway must produce generalist doctors who are certified to deliver the full scope of service for Rural Generalist Medicine. The pathway to Rural Generalist Medicine is a 'pipeline' that begins prior to medical school and extends through postgraduate training to lifelong learning.
- 21 The training model must serve to attract and enthuse people to a Rural Generalist Medicine career: particularly young people from rural areas as well as the cities; medical students; and junior doctors. Training models should incorporate best-evidence in strategies that have been shown to produce and retain a generalist rural medical workforce. This includes basing training for Rural Generalist Medicine in rural areas with rotations to larger centres only as training requirements dictate.
- 22 Curricula in undergraduate medical education must include strong generalist content and include greater participation of doctors practising Rural Generalist Medicine as teachers and preceptors.
- 23 Post-graduate training curricula that reflect the full scope of Rural Generalist Medicine have been developed by some agencies and can be considered as a reference point for development and strengthening of post-graduate training elsewhere.
- 24 Specific pathways to training in Rural Generalist Medicine should be clear and available at an early stage of medical training, whilst allowing for others to take up training at a later stage. Training structures should allow for flexible entry points and flexible training pathways whilst assuring comparable outcomes at completion. Trainees need support on their journey and allowance must be made for the possibility of a graceful exit.

### **C. Research agenda to advance Rural Generalist Medicine**

#### *Efficient use of health care resources and Rural Generalist Medicine*

- 25 There is good evidence that where populations have access to primary care and generalist doctors, health care systems produce better health outcomes at a lesser cost than when specialised medical care predominates. There is also emerging evidence for the cost-effectiveness of generalist models incorporated into hospital-based care - including in the tertiary setting and particularly for patients living with chronic and complex conditions.
- 26 In order to build the evidence base to support rational health care investment decisions, further study is required in areas such as: cost analysis and cost-benefit analysis of alternative rural medical care models across a range of geographic contexts, community and institutional health care settings; interventions to retain doctors in rural practice.

*Quality and safety and Rural Generalist Medicine*

- 27 There is good evidence of equivalent or better outcomes of medical care that is provided by generalist doctors working in rural teams for a number of areas, including in provision of maternity services and some surgical procedures.
- 28 Although often assumed, there is actually little evidence of superior outcomes for common health care interventions when provided by specialist versus generalist medical practitioners. There are also methodological flaws in many published studies. In spite of this, a concern for quality and safety of care is often invoked when decisions are made to restrict the scope of practice or limit the location of service by generalist doctors. Similarly, perceptions of risk tend to increase medico-legal hazard.
- 29 All too often, the consequence of often-arbitrary decision-making in cities to restrict generalist practice is a reduced access by rural communities to health care, worse health outcomes and increased costs to individuals and health care providers.
- 30 In order to build the evidence base to strengthen health care in rural communities, further study is required in areas such as: comparative studies on outcomes of care for different rural health care models that take the wider view of community access and context of care into account; comparative studies on effective models of care in discrete areas of service (eg: cancer care in rural areas); methodologies that move beyond simplistic audit of outcomes for particular interventions by individuals to outcomes of 'systems of care' by teams; development of methodologies appropriate for evaluating complex systems; evaluation of different approaches to clinical privileging and credentialing; and more critical study of volume of procedures and outcomes in complex systems.

*Effective models of training and Rural Generalist Medicine*

- 31 Features of medical education and training models that produce and retain a generalist rural medical workforce are increasingly well characterised. These include: targeting medical school admission to enrol rural-origin students; locating medical schools, campuses and post-graduate residency/training programs away from major cities; scholarships and bursaries with return of service obligations; and supporting an enhanced scope of practice in rural areas.
- 32 In order to build the evidence base to improve training for Rural Generalist Medicine, further study is required in areas such as: effectiveness of reform of undergraduate medical education (including socially accountable medical education); effective models of distance teaching and supervision; approaches to trainee selection that take

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into account the qualities and attributes that make for good rural practitioners; training factors that enable, sustain, support and renew the practice of Rural Generalist Medicine.