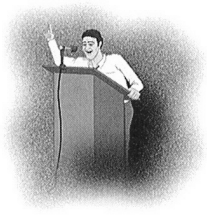

PODIUM: DOCTORS SPEAK OUT
LA PAROLE AUX MÉDECINS

Rural Canadian anesthesia: past, present and future

Hal Irvine, MD, FCFP

Chair, Collaborative Committee for General and Family Practice Anesthesia in Rural Canada

Correspondence to: Dr. Hal Irvine, Bag 5, Sundre AB T0M 1X0; irvineh@airenet.com

Concerns about the sustainability of rural anesthesia in Canada began to be raised in the mid-1980s. Opportunities for postgraduate training for general practitioner anesthetists (GPAs) were decreasing, some of the training being offered was inappropriate, and the length of training offered and felt to be necessary for safe practice was variable. In 1988 the Canadian Medical Association (CMA) sponsored an Invitational Committee with wide representation to come to a consensus on the training of general practitioners / family physicians to provide anesthesia services.[1] There was optimism at the conclusion of these 1988 meetings. The Executive Director of the College of Family Physicians of Canada at the time, Dr. Reg Perkin, reported:[2]

> "The organizations representing Canadian medicine now all agree on the need to provide adequate numbers of funded residency programs for the training of FP anesthetists... The training must be appropriate to the educational objectives of FP anesthetists and will have to take place in clinical settings where this aim can be achieved, including the approval of new community-hospital training sites where indicated... There is now a renewed commitment of support for the practicing FP anesthetist... Teachers of anesthesia may travel to smaller centers on a regular basis... telephone "hot lines" may be available for urgent consultations... the services of locum tenens may be provided..."

Unfortunately, the good intentions of the Invitational Committee failed to materialize. Most of the recommendations produced by these meetings were not generally implemented. This, in part, reflects the challenges facing existing professional organizations to represent and advocate effectively on behalf of GPAs.

While in training, residents are in a third year of family medicine, but they spend their time working within the department of anesthesia without formal attachment or base within that department. On completing their training, they have no base within the Canadian Anesthesiologists' Society (CAS), nor are they members of the Royal College of Physicians and Surgeons of Canada. While most also practise family medicine and have a professional home within the College of Family Physicians of Canada (CFPC), their practice profiles set them outside the scope of most family physicians. Many are international medical graduates, who have no history of affiliation with the CFPC, and some do not practise family medicine at all.

When professional issues relating to training, competence, professional development and clinical standards of practice are discussed, there has been no professional or academic group with the responsibility and mandate to speak for rural GPAs.

Fortunately, this is changing.

The same concerns with training,

We invite physicians to speak out on issues that concern them. Please send Podium submissions to Suzanne Kingsmill, Managing Editor, *CJRM*, Box 1086, Shawville QC J0X 2Y0; cjrm@ca.inter.net

accreditation, maintenance of competence and quality assurance that prompted the 1988 CMA Invitational Meetings brought together the Society of Rural Physicians of Canada (SRPC), the CFPC, and the CAS to produce the *Joint Position Paper on Training for Rural Family Physicians in Anesthesia*.[3] Following these discussions, another broadly represented invitational meeting was held in Kananaskis, Alta., in November 2001.[4] Some of the discussions at Kananaskis involved how best to represent and provide a professional home for GPAs in rural Canada. It was realized that no one organization could adequately provide this function, and a collaborative model was proposed: that the CFPC, CAS and SRPC form a Collaborative Committee on Anesthesia (CCA).

This committee held its inaugural meeting in September 2002. The mandate of the CCA is to advocate for rural GPAs by identifying and responding to issues relating to anesthesia practice. The goal of the CCA is to function as an organizing committee with the responsibility to ensure that issues are identified, heard and carried forward toward resolution. Ad hoc working groups will be formed when necessary to address specific tasks. The CCA will also function as a resource for general and family practice anesthesia, its home organizations and outside bodies.

The CCA believes it can best support practising GPAs through 4 main mechanisms:

- supporting the development of national standards of training and accreditation;
- supporting the development and promotion of continuing medical education opportunities that are appropriate for rural GPAs;
- supporting the development of rural-appropriate clinical practice guidelines; and
- developing ways to reduce the professional isolation of rural GPAs.

Much has already been accomplished. There is a rural anesthesia email list, which currently has about 170 subscribers. A database of practising rural anesthetists has been compiled, and this allows a mechanism to communicate with the approximately 540 GPAs in Canada. Parallel to the activities of the CCA, a subcommittee has developed a document outlining national standards for accreditation of family practice anesthesia training programs and a national core curriculum for those programs. This document supports the CFPC initiatives in developing and accrediting advanced skills programs. It will give guidance to university programs on curriculum standards, and establishes the program organization necessary to ensure quality education. Programs will be accredited by the CFPC as part of their accreditation process for family medicine programs. Residents completing training will be given a diploma or other attestation of completion of training that notes that the program has been accredited by the CFPC.

The CCA remains concerned about the sustainability of its activities. To date, it has been supported by Health Canada funding left over from the Kananaskis Conference (with physical space and organizational and secretarial support provided by the CFPC). However, our federal funding expired Mar. 31, 2003. The original idea was that Health Canada would provide start-up funds and the committee would continue to be sustained by the 3 primary stakeholder organizations: the SRPC, CFPC and CAS. Despite an ongoing committment to the activities of the CCA, the ability of these organizations to financially be totally responsible for the CCA in the long term is tenuous in view of all the other and increasing responsibilities they have. The CCA has proposed a model of sustainability, which is a combination of support from the SRPC, CFPC and the CAS with financial contribution from members of a new informal association of GPAs. GPAs could join the new association through membership in any one of the 3 primary stakeholder organizations and would receive some benefits from all 3 groups.

The CCA has determined the following priorities for the next year.

- moving forward with a collaborative model for sustainability of our initiatives;
- supporting CME appropriate for rural GPAs;
- developing a national system of evaluation for international medical graduates with skills in anesthesia;
- developing a national system of evaluation of residents training in anesthesia; and
- encouraging the development of rural-appropriate practice guidelines through liaison with the CAS Standards of Practice Committee.

Despite ongoing challenges, the future of anesthesia in rural Canada has never looked better. With continuing support for other "advanced skills" by our professional organizations, residents of rural Canada will be able to continue to receive services in their home communities from the doctors who serve them.

Competing interests: None declared.

REFERENCES

1. Webber W, chair. Report of the Invitational Meetings on the training of general practitioners/family physicians to provide anesthesia services. In: *Reports to the General Council of the Canadian Medical Association*, Appendix B. Canadian Medical Association Annual Meeting, 1988 Aug 22–24; Vancouver, BC.
2. Perkin RL. Family practice anesthesia. *Can Fam Phys* 1988;34:2105.
3. Working Group of the Society of Rural Physicians of Canada in cooperation with the College of Family Physicians of Canada and the Canadian Anesthesiologists' Society. *Joint Position Paper on Training for Rural Family Physicians in Anesthesia*. March 2001. Available: www.srpc.ca/librarydocs/JPPeng.pdf (accessed 2003 Sept 26).
4. Working Group on Rural Anesthesiology Practice. Determining and sustaining a maintenance of competence program for Family Physician Anesthesiology Practice in Rural Canada: Report of the Working Group on Rural Anesthesiology Practice. Universities of Calgary and Alberta, Society of Rural Physicians of Canada, College of Family Physicians of Canada, and Canadian Anesthesiologists' Society. Feb 2002.

Note: For further information about the Collaborative Committee on Anesthesia or the rural anesthesia email list, contact Dr. Hal Irvine at irvineh@airenet.com or at Bag 5, Sundre AB T0M 1X0.