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A Case Study of Canada's Rural Practice Training 21st-Century Journey

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SUMMARY

Canada is a vast country with about one-fifth of its 37 million people living in rural areas. Many of those, especially Indigenous Canadians living in remote communities, face serious challenges accessing equitable healthcare. Dedicated general practitioners/family physicians have provided most of the generalist medical care in rural and remote communities with specialist care and resources most often limited or distant. There have always been some medical schools that have provided exceptional training for physicians to practice in rural communities. Since 2000, there has been more focus (and progress) on the development of rural training pathways to develop more physicians with both the interest and appropriate skills for rural generalist practice.

While recognizing that the pathways to rural practice begin before medical school, and extend into practice, this case study will focus on postgraduate vocational residency training for rural family practice. It will highlight the challenges and successes of the significant policy, planning and program steps along that journey with particular attention to the roles of the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC). The interplay of medical education and healthcare delivery is complex. For meaningful progress, collaboration is vital, but it is a challenge to achieve. Indeed, collaborative multi-stakeholder action is the essential innovative solution in the development of the rural training pathways in Canada.

CASE STUDY

One can trace this case study back to Dr. William Victor Johnson and the founding of the College of General Practitioners of Canada (CGPC) in 1954. At that time, most rural and urban GPs were generalist practitioners who provided full-scope care in their offices, patients' homes and hospitals, including intrapartum care, emergency and admitted patient care. Dr. Johnston, a rural GP, one of the founders of the CGPC and its inaugural executive director (1954-65), recognized the importance of the rural context. His mentor's dictum quoted in *Before the age of Miracles*, "No one can do better as there is no one else there" still resonates with rural doctors facing critical emergencies when help is distant (Johnston 1972, 15).

In 1964 the CGPC changed its name to the College of Family Physicians of Canada (CFPC) and currently has ~38,000 members, of which approximately 15% are rural family physicians. In the 1960s and 1970s formal family medicine postgraduate vocational training programs (2 years) were established by Canada's medical schools to meet the requirements of the accreditation and certification exams set by the CFPC. These now provide the only formally recognized Canadian vocational training pathway to family practice. Similarly, specialty postgraduate vocational training programs (4-5 years) are provided by Canada's medical schools to meet the requirements, accreditation and certification exams set by the Royal College of Physicians and Surgeons of Canada (RCPSC). In Canada, a pre-requisite for Canadian graduates for full licensure is certification with either the CFPC or the RCPSC.

In response to a physician shortage for Canada's growing population, four new medical schools took their first medical students in 1969-70: University of Calgary, McMaster University, Université de Sherbrooke and Memorial University of Newfoundland. Memorial, established in St. John's with only 100,000 people, had a social accountability mandate to serve an isolated and mostly rural Newfoundland and Labrador population (Rourke et al 2018). The Northern Ontario Medical School -Canada's 17th medical school– admitted its first medical student class in 2005. Its rural and northern focussed curriculum includes a rural longitudinal integrated clerkship (Strasser et al 2013).

With the increasing availability of urban specialists by the 1980s and 1990s, the scope of practice of many urban GPs narrowed with few providing the hospital services that were essential for the rural GP/FP to provide. With medical school education and postgraduate training almost exclusively urban-centred, there were few rural role models and a lack of practical skills training in rural contexts needed to encourage and prepare physicians for rural general practice. Furthermore, this urban-centricity was reflected in health care planning, policies and program support and even in the structure and function of medical organizations, medical schools and hospitals. This disconnect with the realities of rural patient care prompted rural communities and their rural physicians to push for better access to rural health care.

The grass-roots establishment of the Society of Rural Physicians of Canada (SRPC) in 1992 grew from a need for action. With its vision "Excellent health care close to home for all rural Canadian" and mission "Championing rural generalist medical care through education, collaboration, advocacy and research" the SRPC has become the national voice of Canadian rural physicians. Although a small organization (currently ~1900 members), it has a dynamic leadership and has leveraged its members' roles in other medical organizations including the CFPC, RCPSC, Canadian Medical Association (CMA), provincial medical associations as well as in medical schools and healthcare organizations to advocate for rural healthcare improvement. The SRPC's annual Rural and Remote Medicine conference has become the essential rural continuing medical education and networking conference in Canada.

With the establishment of the SRPC, the clarity of role and turf between the CFPC and SRPC in the early years created some tensions. With time and intention, the CFPC and SRPC jointly became powerful allies advocating for rural health and changes to postgraduate vocational training for rural practice.

The CFPC collaborative Working Group report *Postgraduate Education for Rural Family Practice: Vision and Recommendations for the New Millennium* set out a bold way forward and provides a good starting point for this 21st-century journey (Working Group 1999). The chair described the mandate as "What a challenge! Fifty questions" that began with "What is rural? What is rural practice? Is rural family practice different?", and probed, "How should doctors be trained for rural practice?", and wondered "Is anybody listening? Is rural health care a priority?" "Is rural Canada destined to remain short of physicians, under-serviced, under-supported, and under-funded with second-tier health care access?" (Rourke 1999). Twenty years later these questions remain but significant progress has been made.

Recommendations from that working group provide five key reference points for that progress, i.e. the what, and our discussion of the how, and the why.

1. "Core undergraduate rural education experiences are necessary for all medical students."

This has been almost fully implemented in Canada's 17 medical schools. The Association of Faculties of Medicine of Canada (AFMC) *Future of Medical Education in Canada FMEC-MD* (2010, 16,24) report recognized the social accountability need for medical schools to educate physicians for all parts of Canada. It also highlighted the importance of undergraduate learning experiences in helping shape medical students' postgraduate training and future practice type and location decisions. The FMEC-MD recommendation #6: "Diversify learning contexts:" specifically includes "small rural communities". The Committee on Accreditation of Canadian Medical Schools (CACMS) (2018, 11) adapted this into Standard #6.4.1: "Clinical learning experiences for medical students occur in more than one setting ranging from small rural or underserved communities to tertiary care health centres."

2. "Core postgraduate rural or regional community-based rotations are desirable within all programs along with sufficient rural elective opportunities for all residents."

This was rapidly fully implemented in 2000 when the CFPC mandated: "All Family Medicine (FM) residency training programs must include at least two months of rural experiential learning".

3. "Rural family medicine training streams should be developed as appropriate postgraduate training for rural family practice", "The number of rural family medicine training stream positions should reflect rural healthcare requirements", "Rural family medicine training streams should be community– based, integrated programs with full academic support" "A minimum of six months postgraduate education should occur in rural settings", "These rural streams should be recognizable to medical students when they make application to the Canadian Residents' Matching Service (CaRMS) or alternative match in Québec."

There has been a steady increase in medical student and postgraduate training positions in Canada. From 2000-2018, Canadian MD degrees awarded increased from 1578 to 2,860 (AFMC data). From 2000-2019, vocational trainees completing Canadian postgraduate programs

increased from 1735 to 3543, with Family Medicine's rising from 703 (39% of total) to 1,488 (42% of total) (AFMC, CAPER data). Much of the additional medical school postgraduate capacity for FM training was developed in rural and regional communities (see Illustration).

The AFMC *Collective Vision for Postgraduate Medical Education in Canada FMEC-PG* (2012, 13,14) report recommendation #1 stated, "…the PGME system must continuously adjust its training programs to produce the right mix, distribution, and number of generalist and specialist physicians….". It recognized "the differing needs of rural and urban health care". Government financial support was vital and provided with the expectation that physicians would be more likely to choose to practice in the communities (or similar) and that training-in-place would be more appropriate for and improve the transition into rural practice.

This decentralization of FM postgraduate training sites led to the development of many de facto rural training streams; however, it was not until 2020 that the CaRMS match identified rural training streams. This delay may have been partly because some FM leaders felt that all MDs trained in all Canadian FM programs should be prepared enough to begin rural practice. However, it was clear to rural doctors and medical students and residents that the de facto rural training streams provided better preparation for the realities of rural practice. Indeed, most physicians now entering rural family practice do so from de facto rural FM training streams.

4. "Competence in the knowledge, skills and attitudes for rural family practice should be the goal of rural family medicine training programs", "Curricula and education content should be based on the clinical reality of rural practitioners building on the template problems and procedures in the appendix to report."

The idea of competency-based vocational training directed to anticipated rural practice needs formed the basis for the Australian College of Rural and Remote Medicine's (ACCRM) (2020) *Rural Generalist Curriculum* vocational training, but was ahead of its time in Canada. Established in 1997, ACCRM's independence from the RACGP, allowed it to focus dynamically on developing specific training for rural practice. In contrast, the CFPC maintained the ideology of the benefits of a broad-based universal curriculum for family practice. By 2011 the CFPC had developed and then implemented the *Triple C Competency Based Curriculum* for all Family Medicine PG programs. (Oandasan 2011, College of Family Physicians of Canada 2020). After a lengthy development and deliberation, the CFPC formally approved *Priority Topics and Key Features for the Assessment of Competence in Rural and Remote Family Medicine* in 2019 (College of Family Physicians of Canada 2019a).

5. "Rural family physicians should continue to be trained in advanced family medicine skills including general anaesthesia, general surgery, advanced maternity care including caesarean section, and other advanced skills such as psychiatry where there's a demonstrated need.", "The CFPC (preferably conjointly with the RCPSC and with input from licensing bodies) should accredit advanced rural medicine skills training programs"

Following years of collaborative effort, in 2019, the CFPC approved training with Certificates of Added Competence (CAC) in *Obstetrical Surgical Skills (OSS)* and *Enhanced Surgical Skills*

(ESS), in addition to previously recognized Family Practice Anaesthesia and Emergency Medicine (College of Family Physicians of Canada 2019b, 2019c; Orser et al 2019).

This 21st-century CFPC-SRPC journey began with CFPC Working Group on Postgraduate Education for Rural Family Practice as an informal collaboration with the SRPC (Working group 1999). At that time, the conditions looked promising for a significant rural leap forward. Health Canada had established an Office of Rural Health with Dr. John Wootton, a rural physician, as executive director. Health Canada's Ministerial Advisory Council on Rural Health involved key pentagram stakeholders. Its report *Rural Health in Rural Hands: Strategic Directions for Rural, Remote, Northern and Aboriginal Communities* (2002) contained expectations for major structure and funding as did *The Health of Canadians* (Kirby, LeBreton 2002). Alas, with a change in government, support for rural improvement seemed to wash out like the tide. Rural communities and their physicians became disappointed and frustrated with the lack of progress in big system change. Seeing the progress being made in Australia by ACCRM, some rural physicians called for a separate rural training college in Canada. Still, there was little opportunity or potential for developing that within Canada's regulated medical education and health care system.

Leaders in the SRPC and CFPC realized that a CFPC-SRPC rural-focussed partnership was needed to continue to push progress so established the Advancing Rural Family Medicine Canadian Collaborative Task Force in 2014. In 2017, the Task Force released its *Rural Road Map for Action: Directions* that set out 20 recommendations for a renewed approach to strengthening rural physician workforce planning through education, practice, policy and research. (Advancing Rural Family Medicine 2017; Bosco and Oandasan 2015). Recognizing that broader collaboration would be needed to move the recommendations into action, the Rural Road Map Implementation Committee (RRMIC) was established in 2018 (Wilson et al 2020).

In 2020, RRMIC is undertaking a five-year *Review on Rural Medical Education* that will evaluate the current environment within medical education and how it has changed since the 2015 environmental scan (Bosco et al 2015) to encourage and train more rural generalist physicians as outlined in the recommendations of the Rural Road Map for Action. The purpose is to determine whether progress has been made in promoting and retaining physicians in rural settings as well as assessing gaps in implementation of rural medical education.

CONCLUSION

Substantial progress has been made developing the postgraduate rural training pathways in the 21st-century. Now postgraduate residency rural FM training streams in many rural communities all across Canada provide experiential learning with rural physicians to develop the rural competencies needed for rural practice (see Illustration). However, as identified in the RRMIC progress report (Wilson et al 2020) and the COVID-19 pandemic found, more rural health system reform is needed to recruit, retain and support an appropriate rural health workforce.

As challenges remain, medical schools and residency programs must recognize the importance of providing learners with robust experiences in underserved communities as well as training across the continuum of learning in order to support the needs of rural populations and address the maldistribution of Canada's physician workforce. Medical schools, postgraduate medical

education programs, and certifying bodies need to work together to enhance the delivery of rural medical education and support physician readiness, competence, and willingness to practise in rural and remote communities. Educational pathways are necessary to produce and support a rural generalist workforce. These pathways offer curricula that provide necessary early and ongoing educational opportunities in rural, remote, and Indigenous communities. These also need to include medical education with respect to specialist training in rural settings (more specifically, general pediatrics, general internal medicine, general surgery).

While it is recognized that education is considered a key factor in the development of the rural workforce, it is, however, not sufficient. Many other factors play influential roles. Direction 1 of the Rural Road Map for Action responds to the call for solutions to secure the right mix, distribution, and number of physicians in this country. Efforts should focus on reinforcing the social accountability mandate of medical schools and residency programs to address health care needs of rural and Indigenous communities. Along with educational initiatives, health human workforce planning, policies supporting remuneration of rural physicians, community engagement, and support for rural practice networks are also required.

Big changes in a complex system require multi-stakeholder collaboration with a vision that resonates with all. "Quality Care Close to Home for all Rural Canadians" is a vision that has been uniting. With it comes recognition of the important link of education with successful rural practice recruitment and retention. Canada's highly regulated medical education and healthcare systems require long-term committed, co-ordinated, collaborative advocacy and action as demonstrated in this case study, highlighting it is a marathon and not a sprint to the finish line. There are significant inequities in accessibility to health care for Canadians living in rural and remote communities. The lack of access oftentimes translates to poorer health outcomes and increased overall burden of disease. By improving medical education to shift focus to rural training and retention, these health inequities can potentially be mitigated.

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DISCLAIMER

The interpretations in this article are those of the authors and not of the organizations listed in which they have had various roles.

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