GENERALISM IN RURAL MEDICINE

Mini-symposium 1. - 2. September 2016

Sydspissen Hotel and Medicine& Health Building, Tromsø

National centre for Rural Medicine/
Boaittobealmedisiinna našunála guovddáš
UiT the Arctic University of Norway

2016

UiT
THE ARCTIC
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OF NORWAY

International mini-symposium
1.-2. Sept 2016 – TROMSØ NORWAY
on generalism research in rural medicine

UNIVERSITY OF TROMSØ

UiT / THE ARCTIC UNIVERSITY OF NORWAY

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SUMMARY

1st and 2nd September 2016, approximately 60 researchers with a special interest in generalism in rural medicine met in Tromsø, Northern Norway, for a mini-symposium. They were invited to workshop in-between two larger Summits and "in-between" the two large continents Australia and North America. The first Rural Generalism Summit took place in Cairns (2013), the second in Montreal (2015), and the next summit will be back in Cairns, Australia, next year.

The intention was to create a place to share knowledge, plans and ideas; get an overview of what is going on around the world; a chance to revisit and clarify goals; thinking of the values we really want to define; do research that captures what makes rural generalism so different & important; and finally, do some initial collaborative work.

Group work on ten predefined topics constituted most of the mini-symposium. This report shares the rich and diverse work that emerged during three group sessions, along with some photos. The workshop members chose to either stay in one group for all three session, divide their time between two groups, or take part in three different groups.

In addition, a taste of generalist medical care in Norway was given by the President of Norwegian Medical Association, Rural GP Marit Hermansen, and researchers in Tromsø or connected to National Centre of Rural Medicine. Their topics were The Norwegian health system and rural medicine (Birgit Abelsen and Helen Brandstorp), being a GP in the Nordic Countries (Per Stensland and Carl Edvard Rudebeck), and the new medical curriculum in Tromsø (Torsten Risør)

18.10.2016

Helen Brandstorp
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Topics of the groups

1. Defining the nature and scope of practice of rural generalist medicine

2. Telemedicine and technological innovation in rural medicine

3. Clinical courage in context – the interaction between location, access, quality and safety in RG practice

4. Rural generalist training, workforce & professional development

5. Rural and remote indigenous health

6. Rural generalist medicine in developing countries

7. Rural health equity

8. Translation of research into policy – models and case studies

9. Rural and remote communities that lose, or about to lose, health care services and sustainability

10. Rural and remote medical education research
Acquisition of specialised skills & maintenance of professional standards

The picture shows the Sami peoples' movable and flexible construction called lavvo, without the lavvo cloth wrapped around the poles.

It is similar to a North American tipi, but the mechanism holding the poles together in the top is different. You have to look close and have some insight to see it.

The sami lavvo construction has three Y-shaped poles as a basic structure that the rest of the poles build on to. The poles are also shorter and less straight than tipi poles, because the trees are different. Context matters.

1 DEFINING THE NATURE AND SCOPE OF PRACTICE OF RURAL GENERALIST MEDICINE

Workshop members: Ewen McPhee, Braam De Klerk, Roger Strasser, Chitkasaem Suwanrath, Lars Agréus, Johann Sigurdsson, Linn Getz, Per Stensland, Akil Islam, Greville wood, David Mills, Carl Edvard Rudebeck, Sandy MacDonald, Jim Rourke (facilitator)

Rural Generalist Practice is different/unique.

- Community context
    - Community resources…
    - Time and distance to specialized…
    - Needs of community
        - Individual and population health
        - Access challenges
    - Role of RGP
        - Joys/challenges
        - Clinical courage, resilience
        - Broader scope needed
        - Complexity
        - Emergencies are unavoidable
        - Life and work in community
    - Rural team
    - Local workforce limitations

- Health System
    - Regional Network/support/resources
    - Regulations

- Research
    - Determinants of health
    - health status
    - health care outcomes
    - heath care access and utilization and costs
    - Generalist vs highly specialized care impact on communities
    - Recruitment and retention

- Education for RGP
    - Needs driven
    - Context based

The positive effect on the quality of care given depends on that we "work and live in visible networks". The social and also medical knowledge that we have (or get over the years) if we are adaptive, also of the co-workers that has been there for long, or even are born and bred in the area, are great advantages. This context does not exist in larger urban settings!

Report of the Generalism and Generalist Task Force RCPSC 2013

Generalism is a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs.

Generalists are a specific set of physicians and surgeons with core abilities characterized by a broad-based practice. Generalists diagnose and manage clinical problems that are diverse, undifferentiated, and often complex. Generalists also have an essential role in coordinating patient care and advocating for patients.

The generalist, aware of a patient's social circumstances, is able to understand the patient in the context of their world and can therefore effectively intervene to prioritize care.

"The generalist undertakes that a patient's needs will be met." (B Fitzgerald, Rural General Surgeon)

Generalist physicians are particularly needed in rural and regional communities because of the time and distance separation from highly specialized physicians and medical services.

Cairns Consensus 2014: 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 practise 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.

2 TELEMEDICINE AND TECHNOLOGICAL INNOVATION IN RURAL MEDICINE

Workshop members:

David Hogg, Anne Silviken, Hsu Chao-Yu, Hildigunnur Svavarsdóttir, Sandy MacDonald, David Mills, Sigurđur Sigurđsson, Ewen McPhee, Peter Berggren, John Hogenbirk, Chitkasaem Suwanrath, Johan Sigurđsson, David Heaney, Dean Carson, Jennene Greenhill, Kanyika Chamniprasas, Phil Wilson (facilitator)

A wide range of technological innovations to improve rural healthcare were discussed in the three workshops. This brief summary attempts to draw a few major themes together. In trying to conclude anything about developing a research agenda in this area, it may be useful to think about all this within the context of the UK MRC Framework for the Development and Evaluation of Complex Interventions [1, 2].

Defining the problems

Equity. We heard a lot about the 'Inverse Connectivity Law' – in other words the availability of communications technology is roughly inversely proportionate to the need for it. Some areas, even in the developed world near to cities, have very low or no bandwidth.

There seems to be little logic involved when we try to make international or regional comparisons of bandwidth availability (eg. Västerbotten with Arran)

Paradoxically, there is evidence that less remote communities may be more likely to want to use videoconferencing (VC) than more remote ones (some published examples from Ontario)

Old technology. Telehealth not integrated with other health technologies. Problems with legacy software.

Sometimes patients might like the 'old ways' – visits to hospitals can be accompanied by visits to friends or to the shops!

It's important not to disrupt existing well-functioning referral links

Security. Practitioner-to-practitioner solutions may be secure, but difficult to do this with practitioner-to-patient communications

Funding. Payment systems may not have caught up with telemedicine – so in areas with reimbursement systems GPs may not get paid for using it.

Scheduling can be challenging.

Systems need to be designed to work at 'both ends'. It's no use having a great secure email system if emails are sent to someone who never reads their emails [3]

Potential solutions.

Collaboration with local businesses increases political 'clout'. Good communications can drastically reduce carbon footprint which again helps the political argument. The message that technology should allow people to work to the limits of their ability is a helpful one.

Design and integration of software into systems requires clinical leadership.

Technology needs to be designed to work at 'both ends'. Need to consider readiness of users.

Key issue is that people at the 'expert' end of telecommunications system really need to understand the context at the other end. This is one example of situations where 'One size fits all' solutions failed to work in some places and succeeded in others. For example, the support needs of very junior doctors managing patients may be very different from those of experienced rural practitioners, and rural facilities with different equipment and skill mix will require distinctive solutions.

Sometimes apps are just adopted by people without input from health services.

VC technologies have proved valuable in delivering teaching and support to students.

Virtual health rooms, where patients can consult with their doctors at a distance, aided by digital diagnostic equipment, are a great idea but poorly evaluated.

Evaluations

There is a desperate need for economic analyses of digital innovations. Problem is that the timescale of RCTs (slow) and technology development (fast) can be mismatched so that the answers can be irrelevant. But some 'quick and dirty' RCTs are possible to give generalizable results (eg. "what is the cost per QALY obtainable from installing ultrasound equipment in remote emergency ambulances at a given distance from a hospital and with a given caseload?")

There is very little research to inform policymakers or managers about how to get the best value for money from digital technologies. How small or distant does a community have to be to justify a virtual health room, how busy or distant does a community hospital have to be to justify buying robot ultrasound kit?

There have been a few examples of robust evaluations (eg. in relation to dialysis and depression management) but in general progress is made, and money is spent, on the basis of very poor evidence, and sometimes on no evidence at all.

There are great technical challenges in applying evaluation evidence in radically different environments (geographical, economic, political) – not many useful tools.

One big problem is the tiny number of experienced academic evaluators working in this field – getting research funding for anything "Rural" is very difficult and consequently Universities are reluctant to offer capacity-building funds to get work off the ground.

References

1. Craig PD, P.; Macintyre, S.; Michie,S.; Nazareth,I.; Petticrew,M.: Complex interventions guidance www.mrc.ac.uk/complexinterventionsguidance. In.: MRC; 2008.
2. Graham M, Audrey S, Barker M, Bond L, Bonell C, Hardeman W, Moore L, O'Cathain A, Tinati T, Wight D et al: Process Evaluation of Complex Interventions: MRC Guidance.: Medical Research Council; 2014.
3. Sampson R, Barbour R, Wilson P: Email communication at the medical primary–secondary care interface: a qualitative exploration. British Journal of General Practice 2016, 66(648):e467-e473.

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Ready for joint sessions on day 2, in front: Braam De Klerk (Ca), Jill Konkin (Ca), Garry Nixon (NZ), Greville Wood (NZ) Photo: Katharina Blattner

3 CLINICAL COURAGE IN CONTEXT – THE INTERACTION BETWEEN LOCATION, ACCESS, QUALITY AND SAFETY IN RG PRACTICE

This group developed and refined a research project to progress as a collective. Below is an outline of the proposed study.

Proposed researchers

Lucie Walters (facilitator), Jill Konkin, Katharina Blattner,

Possibly also Torsten Risør's research student Resha Al-Azzarri

Others interested invited to email Lucie.walters@fllinders.edu.au

Purpose

Many countries across the world suffer from a maldistribution of health professional personnel which contributes to poor access to essential medical services and poorer health outcomes. In an attempt to redress this maldistribution, governments have invested huge financial resource in rural undergraduate, postgraduate and vocational training pathways. Despite this, a considerable percentage of students trained in these pathways see rural practice as too hard.[1]

Certainly, normative values in medicine are risk adverse and tend to consider quality and safety of medical practice in terms of risk avoidance, often seeing rural doctors as irresponsible in their recognition and management of risk (cowboys). On the other hand, rural doctors sometimes describe deeply held beliefs about the need to stretch their scope of practice beyond their comfort in order to attend to the access issues their patient's experience. This process is not done with naïve knowledge of, or blatant disregard for, their patients' risks. But with courage. I term this phenomena "clinical courage". A literature search for the term "clinical courage" found only a few references,, demonstrating minimal formal exploration of this concept (Dunlop 2011, Wootton 2011).

The purpose of this research is to explore clinical courage in order to understand its role in the context of rural practice. The ensuing collective understanding of clinical courage will inform rural health professional training and ongoing professional development.

Epistemology

This study uses an interpretive constructivist lens assuming no single meaning of clinical courage. The implications of taking a constructivist stance is that the researcher seeks to co-construct understandings of rural doctors' experiences of clinical courage and impact of clinical courage on their rural practice.

Research Design

This study will explore clinical courage through a mixed methods study.

A Hermeneutic Phenomenological study design will be used to explore the common meaning of lived experiences of clinical courage in rural and remote medicine (Vagel 2014). In contrast to empiricist phenomenology which purports the need to bracket the researchers' presuppositions of clinical courage (Creswell 2012), the researchers will share their experience with the reader to make explicit the role of the researcher in the co-construction of interview transcripts (Mann 2011). We have chosen a

[1] FRAME national survey data 2015

phenomenological research design in recognition that clinical courage as the phenomenon seriously interests us as rural clinical researchers and that it exists as a social construct only through rural health professionals' consciousness of it (Vagel 2014).

In addition, an Ethnographic approach will be utilised to explore clinical courage within the culture of rural practice. This approach will situate the meaning of clinical courage within the context of rural practice.

Next steps

Write ethics application and submit to Flinders University Ethics Committee.

References

1. Creswell, J. W. (2012). Qualitative inquiry and research design: Choosing among five approaches, Sage.
2. Dunlop, P. (2011). "Letter: Clinical Courage." Canadian Journal of Rural Medicine **16**(3): 107.
3. Mann, S. (2011). "A critical review of qualitative interviews in applied linguistics." Applied linguistics **32**(1): 6-24.
4. Vagel, M. (2014). Crafting Phenomenological Research. Walnut Creek, California, Left Coast Press Inc.
5. Wootton, J. (2011). "President's message. Clinical courage." Can J Rural Med **16**(45).

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Some of the symposium participants on the bus top:
Dean Carson (Sw), John Wynn-Jones (Wa), Ewen McPhee (Au), Lucie Walters (Au), Roger Strasser (Ca), Jane Greacen (Au), Jennene Greenhill (Au), Katharina Blattner (NZ), Helen Brandstorp (No), Greville Wood (NZ), Frank Remman (N), Garry Nixon (Au)

4 RURAL GENERALIST TRAINING, WORKFORCE & PROFESSIONAL DEVELOPMENT

Workshop members, in the three different sessions: Peter Berggren, Greville Wood, Puttanibul, Allison Turnock (facilitator)

Jun Parker, Jay Erickson, Roger Strasser, Hildegunnur Svavarsdottir, Johann Sigurdsson, Akil Islam, Jeff Nicholson, Allison Turnock

Braam de Klerk, Per Stensland, Akil Islam, Katharina Blattner, Greville Wood, David Heaney, Sandy MacDonald, Allison Turnock

The summary from this group concluded with an intent to deliver targeted post-graduate training resulting in self-aware doctors who can provide comprehensive care of local communities, including public health, emergency care, complex chronic disease management and resource management (including financial and people).

In order to do this we identified a need to collaborate and share former, current and future research. Actions arising from this discussion included:

1. Collaborate on a descriptive analysis of targeted post-graduate training in the rural generalist context internationally *(Allison to seek permission to share template fields of similar project within Australia for completion by participants)*
2. Complete a thematic analysis for the commonalities between programs
3. Consider what a rural generalist would need in addition to these common areas to be localised in your context

The idea of this is to have a record of what is currently occurring, so that we can learn from each other. Also so we can consider which components are common such that transferability may be considered in the future with recognition there will be local components that will be needed in addition to the shared common themes.

There were 3 sessions to discuss this topic. Below is a summary of each discussion.

Session 1: Took the approach of discussing how the training occurred in each different country, including New Zealand, Sweden, Thailand and Australia.

NZ has a 3 year vocational training program which is completed after 3 years in a hospital setting and is Medical Council accredited. At the end of this program you can work in the GP or hospital setting.
They also have a Division of Rural Hospital Medicine, which has a 4 year program, occurring in the hospital only, including a 1 year elective. At the end of this program you can only work in a hospital setting.Dual fellowship is possible.
The primary and secondary care divide is entrenched in registration.
There was question whether undergraduate emersion in rural areas results in retention.

In Sweden, you complete General Practice training (5 years), plus a special skill (6 years total). It is northern centric, with 4 northern counties. It has been recently recognised as a training pathway and was created to

get better candidates to the areas. The work is challenging and the pathway encourages those that are seeking this type of experience. There is an increase in scope, with emergency medicine and ultrasound part of the role. There are not enough GPs in these areas and so there is lots of multi-disciplinary work. There is also a lot of churn, as people move frequently.

In Thailand there are recruitment and retention issues, with increasingly large gaps between GP and Specialist pay. There are 2 GP programs- CPIRD has a rural focus. This includes 4-6 years in rural hospitals, and 3 years in communities after graduation. There is no internship in Thailand. You can work as a GP without additional training, however most students choose to undertake a program.

Some observations and questions arising from this discussion included:

What gives you ongoing competence? Numbers of episodes of care/procedure vs quality of; how many episodes do you need for CPD

What defines scope of practice? Should it be defined by what you can't do, or what you can do? Do you need to be able to do a full scope of practice in order to do some skills ie do I need to have a full orthopaedic skill set, or can I do a simple closed reduction and set a fracture without this. Is this about appropriate case selection?

Is the primary care and secondary care divide useful?

What is continuity of care? Is it continuity with a GP? A practice? A nurse? Something else?

How do we transition between generations? Change in concepts of professionalism, responsibility, home visits, after hours, etc.

Things we need include: Training in telemedicine.

Marketing RMG as a brand.

Education for the Rural Generalist Team, including creation of pathways for allied health, and education on how to work as a team within a practice and within a community.

Session 2: Took the approach of looking at the training program longitudinally- starting prior to medical school selection, moving through the training program, and into workforce sustainability.

There was discussion about diversity in medical students, and the rural student as a provider of care. Rural hospitals were identified as a great place for early post-graduate year placements in Integrated Clinical Learning teams.

There was discussion about selection for Rural Generalist programs. This included diversity, such as rural, indigenous, low SES groups, immigrants. It is important to reflect the diversity of the community in the workforce. The importance of creating a sense of 'I can become a doctor/nurse/physio/etc' in communities was reflected upon. Social accountability was the underlying theme of importance in this discussion.

Networking, and being part of an RG community was highlighted as important.

Workforce sustainability is effected by factors such as payment for service, number of doctors (<4-5 is not sustainable), amount of on-call (<4th daily is not sustainable). It is also affected by the team around you, including allied health and hospital administration. Being part of the community and inclusion of your family within that community is also important for sustainability. It was noted that 50-70% of RGs in the future will be female, and this may also have implications for workforce sustainability.

Ongoing skills maintenance was discussed. The identification of the underperforming GP was looked at from the perspective of how they are identified. Patient self-selection, county medical officer reports and CME programs were all identified as possible arrangements. Learning communities were highlighted as an important factor for ongoing skills maintenance.

Some observations and questions arising from this discussion included:

What do we need to train in for the future?

Things we need include: A minimum international 'standard' or 'curriculum' for RG

Marketing of GP outside cities (currently seen as 'second rate' in some areas)

Session 3: Took the approach of listening to the summary and coming up with some actions to move forward with.

An agreed starting point would be to document what is currently happening in each country. What is common, rather than different. What is happening in local countries versus in the global community? Is mutual recognition possible? Is it possible to have an agreed program covering 70% of material, and modules specific to local contexts to upskill those new to an area or practice? This should include local culture, health systems and medical information.

Some observations and questions arising from this discussion include:

How do we best collaborate? Through which avenues and contacts?

Do we need a joint political statement on issues such as solo work?

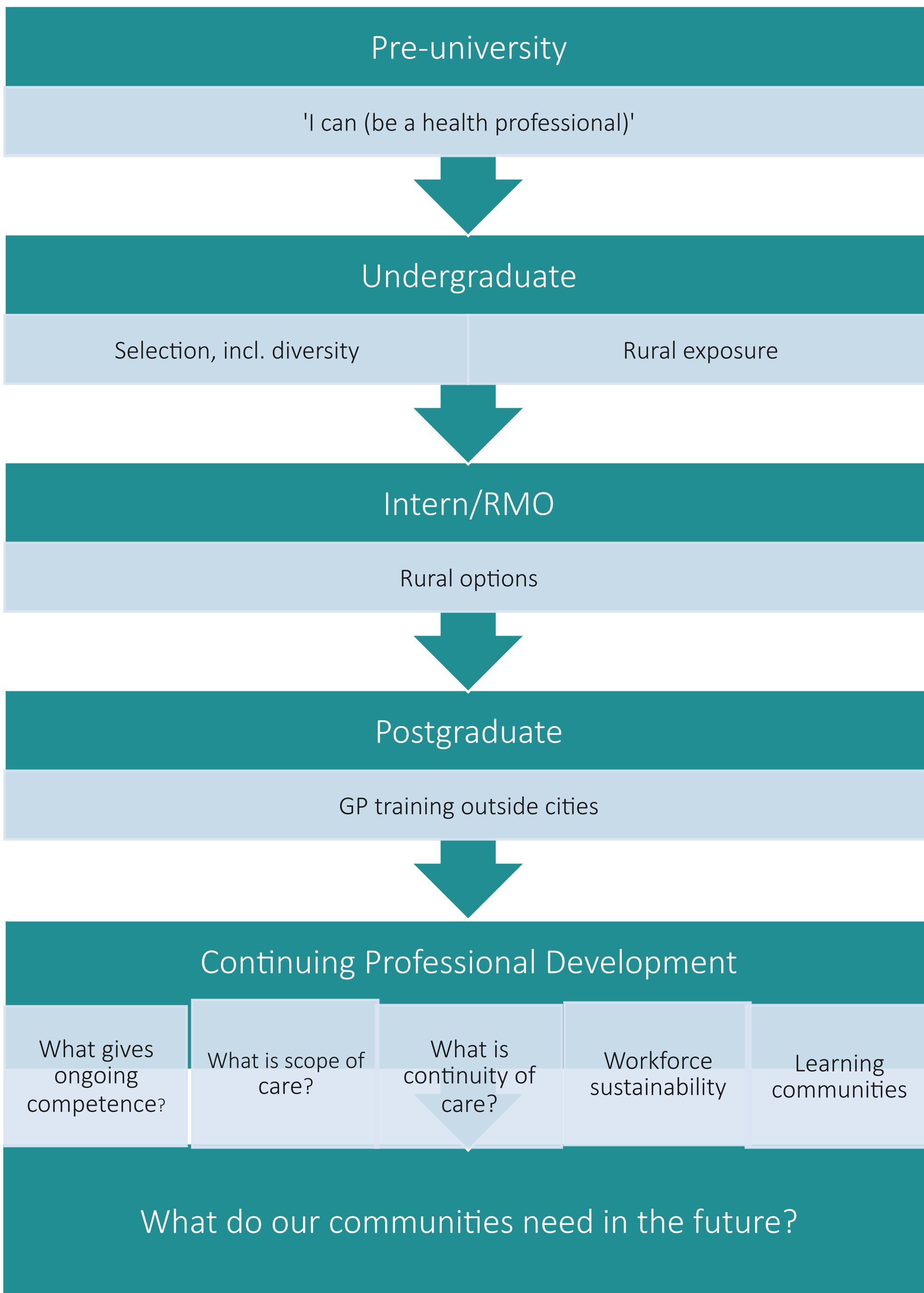
How do we improve communication between GP and secondary care?

Can we share any research or evaluations that already exists? Is there a central place to do this?

Who delivers RG care? GPs, nurses, generalist specialists, other.

How do RG graduates feel about their training on reflection?

Other questions culminated in the overall intent and actions outlined in the initial summary on page 15.



International Standard or Curriculum

Community

IPL and Teamwork

Social Accountability

Rural Generalist brand

5 RURAL AND REMOTE INDIGENOUS HEALTH

Workshop members:, Gary Nixon, Sandy MacDonald, Ingrid Petrikke Olsen, Ivar J. Aaraas, Anne Silviken, Geoff Nicholson, Helen Brandstorp (facilitator)

In the two first sessions, the conversation were mainly attempts to clarify past and present history of indigenous peoples of New Zealand, Australia, Canada/Nunavut and Norway. Although the peoples share many of the traumatic experiences due to harsh assimilations processes in each country, through the school system, church and other official policies for more than 100 years, there are also important differences. Never the less, all participants agreed on the obligation academic institutions has to work with indigenous issues and facilitate context sensitive education of indigenous students and others.

In the third session, the issue of suicide behaviour came up as a common public health problem among Indigenous people. Several commonalities were discussed e.g. the high suicide rates among young males, clusters of suicide and challenges to give bereaved after suicide proper support and help. The group discovered that one of the workshop members, Geoff Nicholson, was planning a large study in order to prevent suicide among Aboriginals in Australia, which includes the program ASIST (Applied Suicide Interventions Skills Training). Nicholson was looking for someone with competence in suicide prevention among indigenous and especially the implementation of ASIST. Another workshop member, Anne Silviken from Norway happened to hold skills in suicide prevention among the Sami people and to have long experience with implementation of ASIST. The discussion gave inspiration for future cooperation and exchange of experience.

Second workshop session in the group: Ivar J. Aaraas, Sandy MacDonald, Jane Greacen

6 RURAL GENERALIST MEDICINE IN DEVELOPING COUNTRIES

Workshop members: Katharina Blattner, Charas Suwanwela, Nitaya Suwanwela, Kristine Andreassen, David Mills, John Wynn-Jones, Lachlan McIver (facilitator)

Overview

"Rural generalism" is the de facto practice for the majority of doctors in most developing countries, despite the dodgy terminology!

RGs in developing countries are a highly heterogeneous group

Common issues distinguish them from developed-country colleagues

Very few resources is available to develop and support this professional community

The voices of this professional community are not well heard internationally

Key issues & challenges

Engagement – communication, advocacy, representativeness

Professionalism – training, scope, competency, identity, CME

Systems support – financial, political, structural

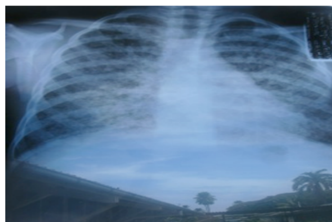
Socioeconomic inequity and resource limitations

Impact of "medical internationalism" – e.g. Cuba, China, Philippines

Integration with national health systems (i.e. not external/isolated/self-imposed support)

Terminology!

...and there are other types of challenges!



Needs & opportunities

Representation of RGs in developing countries is key to enabling greater engagement and better support

Understanding the "who", "what", "where", "how" and "why" questions are of critical importance

Formalised training and professional development pathways are much-needed and will typically require external support

Evidence base for RGM needs to be strengthened

"Best practice" models of care, economics, ICT innovations etc

Recommendations & next steps

Advocacy

- Policy and political support for RG practitioners and systems
- Establishment/strengthening of rural societies
- Linking across countries
- Communications & sharing resources
- Strengthening sense of pride and professional identity

Partnerships

- Collaboration on programmes
- Between institutions
- Between organisations

Education

Engagement

- Representativeness – national/regional groups

- Conferences

Specific research questions

What examples of developing-country RG models (training, systems, representation etc) exist and can be described/evaluated?

- E.g. PNG, Cook Islands, Timor-Leste, South Asia, South Africa

Which developing countries have rural societies/=?

- What function(s) do they have; what forms do they take; and how could these be better supported?

What factors contribute to RG workforce recruitment, retention & satisfaction in developing countries?

- Value/impact of compulsory rural placements?

What are the impacts of RG models of care in terms of efficacy, cost-effectiveness etc?

- Outcomes – individual vs community
- Effects on admission, referrals
- Patient and institutional experiences & expenses

What are the “best practice” models of generalist care in developing countries?

- How can these be established/better supported?
- What innovations (e.g. ICT) are most effective?

What WE can do ☺

Design and implement research projects related to developing-world RGM

Join WWPRP Google Group

Share your experiences in developing countries

Communicate with developing-country colleagues

Submit abstracts for Wonca Rural/World Summit on RGM in Cairns

Identify sources of funding and other support for RGM in developing countries

Roadmap from Cairns to Kampala

Establishment of international network/ collaboration on RGM in developing countries

7 RURAL HEALTH EQUITY

Workshop members: John Wynn-Jones, Jun Parker, Garry Nixon, Kristin Juliar, Ewen McPhee, Charas Suwanwela, Nitaya Suwanwela, Mante Hedman, Carl Edvard Rudebeck, John Hogenbirk, Remo Ostini (facilitator)

The group's discussions coalesced around three topics:

1. Definition of the issue
   a. What is health equity?
   b. What form does inequity take?
2. The problem of data
   a. Lack of information from rural areas
   b. Research challenges
3. Role of generalism in health equity

I. Definition of the issue

What is health equity?

Health equity can be defined in terms of: healthcare funding; health facilities; health service access (cost, physical availability, cultural accessibility); health service delivery; and health outcomes.

How equity is defined will determine the rural health equity research agenda.

Health equity should be distinguished from equality in some instances. Specifically, if health needs differ between urban and rural areas then providing equal services or funding or facilities, or implementing a specific policy equally will be inequitable when it does not meet local need. The prospect for a long, fulfilling life, not disadvantaged by living in a rural area is the goal of health equity.

Health equity is often expressed in terms of funding for facilities, infrastructure and services – often because this is a clear policy lever – even though amount of funding may not be as influential as the target of funding, for the purpose of health equity. In the context of rural health, funding considerations must also extend beyond medicine to include integrated health services (e.g., nursing, pharmacy) as well as education and social services.

The implications of funding on different parts of the health system must also be considered. For example, providing funding to cover the cost of obtaining health services (e.g. universal health insurance) has a greatly reduced effect if facilities to deliver the services are not funded.

Rural health equity can be framed in terms associated with the exercise of power that are common to discussions of minority issues. For example, health policies and their implementation are often designed from the perspective of an urban population, without consideration of rural-urban differences. This occurs when those with power fail to understand the power that they wield and the effect of its use on minority groups.

What form does inequity take?

Inequity in rural areas results from physical as well as social and cultural barriers. In addition to geography, health outcome differences between rural and urban areas are influenced by differences in age, socioeconomic status, and proportions of indigenous and other vulnerable populations.

In order to understand rural health equity the distinctiveness of rural areas must be understood. This should include appreciation of the unique strengths (e.g. social capital) as well as challenges associated with rural areas. Some of the distinctive features of rural areas will be common to most rural areas but in other cases, the distinctiveness of rural areas will vary from one rural area to another.

II. The problem of data

Lack of information from rural areas

Another example of rural health inequity is in the information available about rural areas. Rural communities are disadvantaged by the lack of available information on the characteristics of these communities, including health and social conditions This problem is exacerbated by the privacy implications of collecting and using small area population data.

A further difficulty is the challenge of simply defining rural areas. The compilation of rural health data in New Zealand was provided as an example of this challenge and of the effect that different definitions have on the outcome of health disparity research.

Research challenges

In addition to the lack of rural data, the risks associated with using such data and the implications of misconstruing rurality, there are specific challenges associated with conducting health research in rural areas or with rural populations. This includes the need for specific methods with which to conduct analyses with small group data.

Other challenges include i) the burden of reporting for rural communities, including health care providers; ii) communication difficulties among geographically dispersed rural health researchers; and iii) the challenge of publishing rural health research in high impact journals, which itself exacerbates pre-existing difficulties in obtaining research funding.

The lack of information from rural areas, including the lack of research evidence, has implications for the development of appropriate rural health policy.

III. Role of generalism in health equity

Workforce development (training and ongoing support) is central to the way rural generalism supports rural health equity. With its focus on a population health approach, comprehensive primary care, emergency care and extended procedural practice, generalism has the capacity to address rural health needs in the context of their distinctive features.

In large part, this is underpinned by the generalist's understanding of the specific needs of the community in which she or he is working. This includes understanding community capacity and the scope for developing innovative solutions to health care needs. Within the framework of scope of practice flexibility, this brings together an evaluation of the resources of the community; its disease burden; the distance to the next level of service; and the impact of litigation risk.

Rural generalists also have an important role in advocating for rural communities.

IV. Next steps

An abstract based on the discussions of this working group is being prepared for submission to the WONCA Rural International conference, Rural Generalism day. Interest has also been expressed in furthering this discussion through the WONCA Rural online discussion group. Broadening the discussion in this way could facilitate the development of a structured research strategy around rural health equity as well as building research collaborations.

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Some participants in the mini-symposium: Geoff Nicholson (Au), Ewen McPhee (Au), Akil Islam (Au), Jane Greacen (Au), David Campbell (Au), Garry Nixon (NZ), Katharina Blattner (NZ), Helen Brandstorp (No), Remo Ostini (Au) and Frank Remman (No)

8 TRANSLATION OF RESEARCH INTO POLICY – MODELS AND CASE STUDIES

Workshop members: Birgit Abelsen, David Mills, John Hogenbirk, Garry Nixon, Gry Berntzen, Per Stensland, John Wynn-Jones, Roger Strasser, Manabu Saito (facilitator)

The impact of government policies on rural people, businesses, and the countryside has not always been properly considered, and they have not always been adjusted to take account of specific rural problems. A lack of co-ordination of government policies and activity in rural areas. Rural people feel that they are not sufficiently listened to.

What we want to see:

Systematic assessment of the rural dimension of all government policies as they are developed and implemented - nationally, regionally and locally

Programmes targeted on management of the countryside, for aims which have been agreed with local communities and businesses, co-ordinated to maximise their impact and avoid duplication and conflict

Better arrangements to ensure that government knows what rural communities want, and that the communities themselves are involved in the implementation of policy.

Annual report by the Countryside Agency on the rural aspects of government policies, as well as their annual State of the Countryside report

A rural 'check-list' for Government Departments to ensure that they take account of the rural dimension in developing policy

Better regional co-ordination of Government activities, with MAFF regional strategy staff joining Government Offices

Establishment of National and Regional Rural Sounding Boards.

"Rural proofing is a means to achieve equally effective and successful outcomes for communities, businesses and individuals from policy and in the design and delivery of publicly funded services, regardless of their size or location."

Rural proofing is not a one-off audit exercise but a long-term approach to ensuring that organisations consider rural needs.

9 RURAL AND REMOTE COMMUNITIES THAT LOSE, OR ABOUT TO LOSE, HEALTH CARE SERVICES AND SUSTAINABILITY

Workshop members: Kristin Juliar, Margrete Gaski, Dean Carson, Gry Berntzen, Birgit Abelsen, Hsu Chao-Yu, Sarah Strasser (facilitator)

What the topic implies

The need to do something different in the light of service losses

- Impact on smaller communities
- And on larger ones

Sustainability?

- Of communities?
- Of models of service delivery?

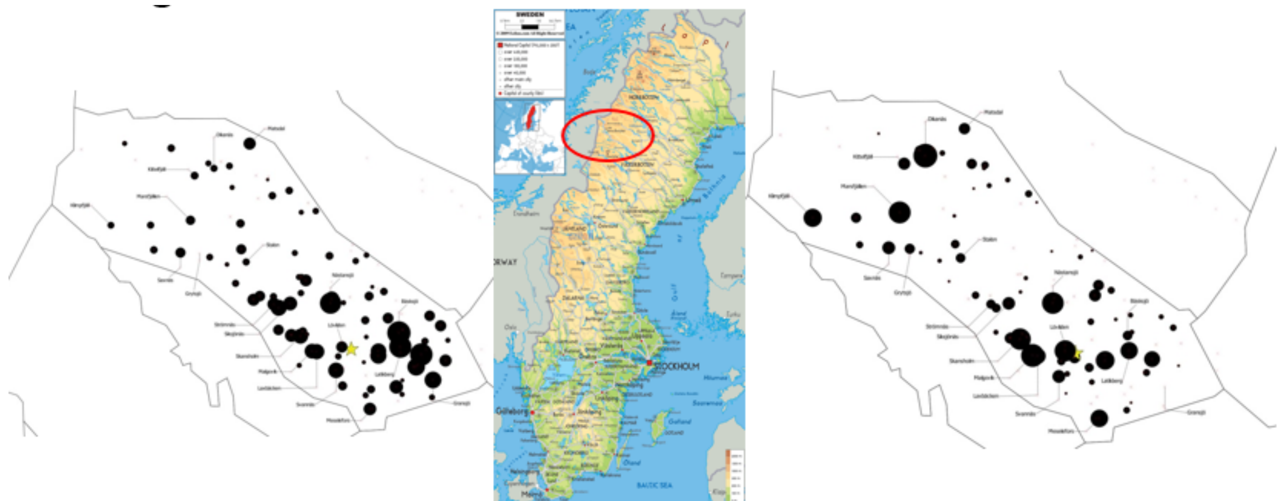
Loss of health services contributing to the demise of the rural village?

Maybe the 'decline' is overstated

Vilhelmina's smaller villages (Sweden)

1900

2015



Some 'adaptations' threaten provision of health services (population loss), some can boost services (ageing).
So it's the services that need to be sustainable…

Hypothesis

That rural generalism is NOT a necessary (or desirable?) component of sustainable models of primary care services in small rural communities in the future

Why the null hypothesis?

The drug (program) my company (medical school) produces is great for your illness (workforce challenge)

Vs

The drug (program) my company (medical school) produces is of no particular value for your illness (workforce challenge)

Bits of a research framework

1. What needs to be known about the context for primary care services? (demography, economy, politics, geography, health status…)
2. What does a sustainable 'non local' (what is local/regional anyway) model of service delivery look like? (and does it look any different if it includes generalism?)
3. How can we anticipate when these models might be needed?
4. How do we select a model of use for this community?
5. How do communities successfully transition to a new model?
6. How do we evaluate if the model is sustainable in this context?
7. How do we prepare for the next adaptation (of model or community)?

What's new in this?

There has been 'sustainable models' research before, but no recent consolidation of knowledge (and maybe new ones eg. with 'e' in them)

'Context' studies are rare, and either too detailed or too 'one size fits all', transferability is often claimed for schemes but not demonstrated.

The implementation cycle (esp. transition) is not well understood

Models and communities are assumed to be static – this research assumes they are dynamic

10 RURAL AND REMOTE MEDICAL EDUCATION RESEARCH. ACQUISITION OF SPECIALISED SKILLS & MAINTENANCE OF PROFESSIONAL STANDARDS

Workshop members: David Campbell, Kasper Øvsthus, David Heaney, Lars Agréus, Mante Hedman, Linn Getz, David Hogg, Hildegunnur Svavarsdottir, Jay Erickson, Ivar Aaraas, Helga Einarsdottir, Torsten Risør (facilitator)

The themes of the group work were the result of the pooling of several themes, all of which concern the relation between learning and rural practice (L-RP). We focused on the need for research on this relation. The figure below shows the core issues in our discussions in the group.

We found three areas of L-RP that need research:

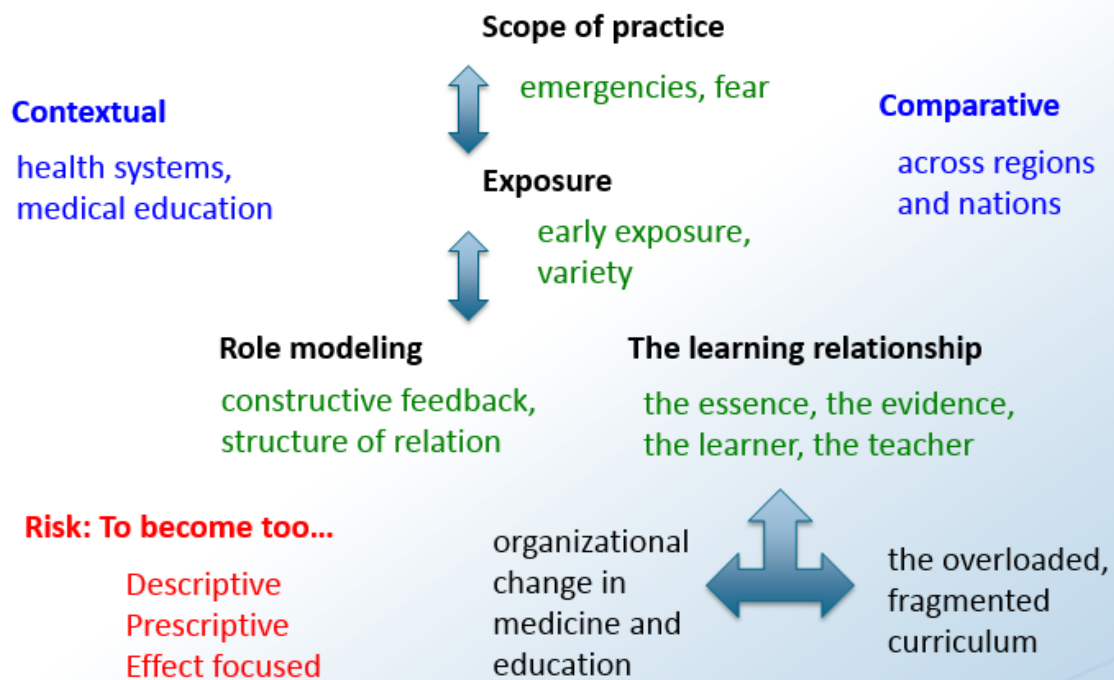
1. Scope of practice in rural medicine – especially medical emergencies and how learners manage the stress and fear of being a participant, even a leader, in such cases.
2. Interaction between GP and learner – including a) the kind of feedback, b) how the relation is structured (time, setting, agenda), c) the roles of both learner and GP and d) the essence of/evidence for the importance of this relationship.
3. Clinical exposure – which includes the forms and effects of both a) early exposure in the medical curriculum and b) the variety of the exposure to patients and clinical work. This point lies conceptually between 1) and 2).

Risk: In the group and in the rural medicine communities, we are all insiders, and we all wish to see that we are doing good and doing right. The result, we argue, is a risk that the study of these themes may become too descriptive, prescriptive and effect focused.

Methodology: To counter this risk, we propose that studies in this framework should be:

1. contextual – analysing data in the context of local health care systems and medical education in the region/country, and
2. comparative – with more than one site in the study and active search for comparison across regions and nations.

In particular, we see the on-going organizational changes in health care and medical education and the tendency to produce overloaded, fragmented curricula as an important limiting and driving condition for the relationship between GP and learner. Therefore, this condition should be included in the analysis of data within this framework.


Learning
Rural practice
“If we wish to focus on the immeasurable
How then can we capture what’s important?”
Scope of practice
emergencies, fear
Contextual
health systems,
medical education
Comparative
across regions
and nations
Exposure
early exposure,
variety
Role modeling
constructive feedback,
structure of relation
The learning relationship
the essence, the evidence,
the learner, the teacher
Risk: To become too…
Descriptive
Prescriptive
Effect focused
organizational
change in
medicine and
education
the overloaded,
fragmented
curriculum

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11 LIST OF PARTICIPANTS AND NATIONS

- Tasmania: Allison Turnock
- Papua New Guinea: David Mills
- Thailand: Chitkasaem Suwanrath, Kanyika Chamniprasas, Puttisak Puttawibul, Nitaya Suwanwela, Charas Suwanwela
- Japan: Manabu Saito
- Taiwan: Hsu Chao-Yu
- USA: Kristin Juliar, Jay Erickson
- New Zealand: Katharina Blattner, Garry Nixon, Greville Wood
- Australia: Lachlan McIver, David Campbell, Jane Greacen, Lucie Walters, Jennene Greenhill, Akil Islam, Ewen McPhee, Geoff Nicholson, Remo Ostini, Jun Parker
- Canada: Sarah Strasser, Roger Strasser, Jill Konkin, Braam De Klerk, Tom Smith-Windsor, James Rourke, John Hogenbirk
- Nunavut/Canada: Sandy MacDonald
- Iceland: Hildigunnur Svavarsdóttir, Sigurđur E. Sigurđsson
- Scotland: David Hogg, David Heaney, Phil Wilson
- Wales: John Wynn-Jones
- Sweden: Lars Agréus, Dean Carson, Peter Berggren, Mante Hedman, Carl Edvard Rudebeck
- Norway: Anne Silviken, Per Stensland, Linn Getz, Johann August Sigurdsson, Ingrid Petrikke Olsen, Gry Berntzen, Kristine Andreassen, Martin Bruusgaard Harbitz, Kasper Kavli Øvsthus, Helga Einarsson, Torsten Risør, Birgit Abelsen, Margrete Gaski, Ivar J. Aaraas, Frank Remman, Helen Brandstorp

Ivar J Aaraas gives thanks to all participants 421 m above the island Tromsø

The life giving sun is a strong, ancient symbol in the north; equal strong is the fireplace – for heating, preparation of food, as a centre for social life, and in the old sami cultures, a respected place of the pre-Christian Sami goddess of birth, transformation and love.

Several stones are needed to keep the fire collected. Each participant in the mini-Symposium thus got a Small, white stone, picked on this spot outside the city, to keep on the way to the seashores of Cairns 2017

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