National Centre of Rural Medicine
NORWAY

Reports from visits to rural communities joined with NSOM

During study tour to Ontario Canada October 2nd 2007

1. **Parry Sound**
2. **Sturgeon Falls**
3. **Mattawa**
4. **North Bay**
5. **Blind River**

Norwegian visitors Tor Anvik, Jan Hana and Ole Bjørn Herland together with driver/guide Rita Campbell, and hosting persons at West Parry Sound Health Centre Norman Mciver, Moe Rynard and Jim Hana.
Photo: Svein Steinert

West Parry Sound Health Centre:
The "Multipurpose area" where doctors, students, nurses and assistants met for discussions and information exchange

1. Parry Sound

Participants from Norway
Jan Hana, GP, Project manager National Centre of Rural Medicine
Ole Bjørn Herland, Senior advisor, Directorate for Health and Social Affairs
Svein Steinert, Acting leader, National Centre of Rural Medicine University of Tromsø
Tor Anvik, Associate professor, Medical School University of Tromsø

Our NOSM guide
Rita Campbell

People we met and what we did
After a safe drive – thanks to Rita Campbell – through the beautiful landscape of Northern Ontario we arrived at the Medical Associates Clinic 30 minutes early.
We were heartily greeted by Moe Rynard who took us on a thorough tour of the premises during a busy time at the clinic. We then were invited to a generous lunch and discussion with dr. David Clarke and many of his colleagues, and CEO Norman Mciver from the West Parry Sound Health Centre joined us. In addition the third year medical students Todd, Anna and Kim from NOSM and Emily from Toronto participated.
We then went to visit the West Parry Sound Health Centre and were invited for a generous tour of the Centre together with Jim Hanna.

What we learned
The Medical Associates Clinic in our view was a busy practice where the doctors went directly from one patient to the next and where the assistants were in charge of bringing along and preparing each patient for seeing the doctor as well as bringing along the medical records. We found that the practice was very well functioning despite of crowded premises and the fact that medical records were on paper only.
We noticed in particular the multipurpose area (the "bridge"?) where doctors, students, nurses and assistants met and were involved in discussions and information exchange about particular patients. We saw this as an efficient and informal way of working together for the sake of the patients. We also noticed that there was a strong local community support for the practice. The discussion with the students gave us insight into some of the challenges that has to be dealt with in real life settings.
The visit at the West Parry Sound Health Centre was an exciting tour of the brand new health centre. We were impressed by the emergency unit, the imaging diagnosing centre and the way the health centre had succeeded in integrating the needs of particular rituals for first nation people in the Shawanaga Healing Centre. We learned much about the role of the family physician in the hospital setting and the emergency unit and about the way they cooperated with the specialists who were attached to the centre. We found that this made it possible to teach integrated health services across levels.

Thanks
Wherever we went, we met people who were very enthusiastic and open-minded, and we felt very welcome. Our deepest thanks to every person we talked with, and special thanks to Rita who gave us a lot of information about the region – the people, their living conditions and their history, at the same time as taking us safely out and back again.

2. Sturgeon Falls

Participants from Norway
Elisabeth Swensen, MD
Anders Stormo, MD
Peder A. Halvorsen, MD

Our NOSM guide
Kim Larkin

People we met
As part of our visit to Northern Ontario School of Medicine, a community visit to Sturgeon Falls was arranged on October 2, 2007. During the car trip from Sudbury Kim Larkin gave excellent information about NOSM's engagement in local communities and general life in the Northern Ontario region. Upon arrival we had lunch with CEO Yves Campeau, two medical students (Carole and Melissa), medical doctors and other staff at the West Nissiping General Hospital. Subsequently the CEO guided us through the entire building including the several units of the local hospital, the teleconference room and the attached health centre of family physicians. Furthermore, the visit included a meeting with a local journalist from the local newspaper.

What we observed and learned
We were impressed by the multi-functionality of the hospital and the attached units. Proximity and interconnection of the units, advanced medical equipment and competent staff indicate good access to high quality medical services. The setup of the health centre – units of two GPs connected by a common back corridor – was very interesting. In our opinion, the local hospital and health centre as a whole provide an excellent learning environment for medical students. No wonder that the students seemed very happy and dedicated.

We met with hard working, experienced physicians who attended to local hospital beds as well as their own family practices, which is not usual in Norway. On the very day of our visit emergency rooms were crowded. There seemed to be shortage of beds and the doctors were busy finding solutions, a scenario quite familiar to us as rural GPs in Norway. Nevertheless, the physicians took their time to meet with us and tell about working life in Sturgeon Falls. We were told that the physicians sometimes experienced difficulties with admitting patients to a higher level of care when necessary. In our country, family physicians are granted the authority to make these decisions. The doctors were concerned about recruitment and retention of younger colleagues and pointed out several key issues such as opportunities for teamwork, backup and good conditions for the spouse, which we recognize as key issues in Norway as well.

We felt very welcomed, especially by the CEO who spent close to an entire working day showing us around. He seemed to know everybody and whatever was going on by heart. He presented a quick method for quality assessment of nursing homes which we will never forget.

3. Mattawa

Participants from Norway
Karsten Kehlet, general practitioner/project manager, The municipality of Lenvik, kehlet@c2i.net
Jon Hilmar Iversen, The Directorate for Health and Social Affairs jon.hilmar.iversen@shdir.no
Margrete Gaski, political scientist and PhD-student, the University of Tromsø, margrete.gaski@ism.uit.no

Our NSOM guide
Ann Moro

People we met
Our main contact persons were Mr. Edward Darby, CEO, and Monique Banks, executive assistant. We also met with the family medicine resident and shortly with to of the other four physicians in Mattawa. The project manager of the new hospital building gave us a guided tour. All of the contacts made this a warm reception and a useful field trip that we really appreciate.

Demography
Mattawa is the oldest settlement in the Nipissing District, located at the old road when going between Ottawa and the west. The population is 2,175. Among those are 870 mother tongue francophone and 400 aboriginal identity population.

Hospital history
Mattawa Hospital was established by the Sisters of Charity in 1878. The hospital is a bilingual, primary and secondary care facility servicing approximately 5000 residents of Mattawa and surrounding townships. The existing hospital is a prefabricated temporary building constructed after the fire in 1966. The part of the hospital which is older is used only for meetings and as a kitchen.

What we observed and learned
Mattawa Hospital is a general care hospital with 21 beds delivering emergency service, long time care and rehabilitation. Compared to Norwegian conditions there are several interesting differences. The integration of general practitioners in the medical services in a hospital of this kind is not unknown in Norway, but rather uncommon. The hospital is well equipped with emergency service equipment, x-ray and ultrasound and an impressive laboratory. I believe we would find few institutions that well equipped in Norway even taking into account the distance to the nearest larger town. The distance from Mattawa to North Bay is around 60 km. One of the major differences compared to Norwegian conditions is the responsibility of the family physician for patients admitted to hospital. Family physicians in Ontario have a much more extended responsibility for the examinations and tests made on the hospital than what we are used to in Norway.
As in rural districts all over the world, Mattawa also faces the challenges of keeping health personnel. The fact that 2 of 4 family physicians are leaving Mattawa in the nearest future makes this a present and considerable problem for the society.

4. North Bay

Participants from Norway

Eivind Vestbø GP and rural advisor National Centre of Rural medicine
Nils Fleten, Associate professor, University of Tromsø
Ivar J. Aaraas Professor and Head, National Centre of Rural medicine
Per Baadnes Administrative manager, National Centre of Rural medicine

Our NOSM guide

Melanie Desloges

People we met

During the day we had the great pleasure to meet many enthusiastic representatives from the local health community. We want to thank all of them for making the trip interesting and awarding for us. We also want to thank NOSM for providing the structure for success. Special thanks to our lovely NOSM guide, for safe driving and excellent comfort including coffee and photo stops at scenic sites. We saw the beautiful Lake Nipissing surrounded by a splendid autumn coloured landscape. Also warm thanks to coordinator Kristen Honeysett at North Bay General Hospital, who was our well informed guide in North Bay.

On arriving in the local community we were impressed by all the local representatives that showed up at the lunch: Physicians, teachers/preceptors, students, other representatives and even the major. We were impressed by the informal and cooperative atmosphere between the locals. They seemed well integrated and appeared to know each other very well.

What we observed and learned

After a good meal and an informal discussion of similarities and dissimilarities in our two health systems, and information about the interesting recruitment project, we were taken to Dr Paul Preston's office. It was interesting to hear how he collaborated with other GP in the Blue Sky Medical Clinic, and how he made the two levels of medical care seamless by following his patients into the hospital. And also how well integrated he was with other specialities on the horizontal level.

From Dr. Preston we went to Dr. Carter's office, where GPs and specialists worked together in a very well equipped clinic. Here we had an interesting talk to the third year student Stephanie Giroux about her experiences in the NOSM rural program. We asked her to score her satisfaction with the education on a scale from 1- 10, and she said 9, - impressing! Another student said 7, so our overall impression was that the students were highly motivated and enthusiastic about the curriculum in general, and the ICE and CCC in special. At last Kristen took us on a round in The North Bay General Hospital. She was very well informed and seemed to know everyone there. Of special interest for us was to see the integration among specialist in the emergency department. It was busy and overloaded, but efficient. We could understand that a more spacious hospital was needed, and it was interesting to know about the plans for a new, modern hospital in North Bay.

In summary we think Norway has much to learn, not only on integrated undergraduate education, but also about recruiting programs and about integration between GPs and specialists, and between the primary and secondary levels of care. We also got a positive impression of increased placement and education of students in rural areas as a way to adjust professionalism and to sensitise future doctors to the diversity of rural and remote communities and their needs of health care.

5. Blind River

Participants from Norway
Ellen Rygh (ellen.rygh@telemed.no)
Per Stensland (per.stensland@isf.uib.no)
Betty Pettersen (betty@poseidon.no)
Elin Baadnes (Per.Baadnes@ism.uit.no)

Our NOSM guide
Brenda Koritko (Brenda.Koritko@NorMed.ca)

People we met
Head nurse M. Luukkonen (mluukoonen@brdhc.on.ca)
Dr. C. Barnes (cbarnes@brdhc.on.ca).

Community
The community **of Blind River** is located 165 km west of Sudbury and has a population of about 4000. The Centre had a catchment area of about 15 000 inhabitants.

The community as presented by NOSM: "A small, thriving community with unique features and benefits. As a busy commercial gathering point, it serves as the sub-regional centre for the communities of the North Shore at Lake Huron. With complete transportation services, available industrial land and near markets in the northern USA and Southern Ontario, this competitive location has surprisingly remained largely unexploited for obvious industrial development advantages. Community website: www.blindriver.ca

Organisation
The Blind River District Health Centre is a fully equipped modern facility with a bed capacity of 58 beds including 16 acute care beds, 10 Complex Continuing Care, 10 ELCAP (?) and 22 long-term care beds. There is a 24/7 Emergency Department. The Health Centre provides a wide array of outpatient diagnostic (laboratory, diagnostic imaging with connection to PACS) therapeutic and community services. The Health Centre has speciality visiting clinics in several specialities, and also provides a wide variety of speciality consults through NORTHNetworkTelehealth.

This rural, rather remote area is served by 3 family physicians, from their general practice and in the emergency facilities and nursing home close by. We did not get to see any of the other health care services in the community.

Observations of the facilities
- Modern, *extremely well* equipped district health centre as viewed from our perspective!
- The family practice efficiently organized and dimensioned with two treatment rooms for each physician, which seemed necessary for the number of consultation per day in a short period of time in the afternoon.
- The family practice did not have electronic patient records, but where planning for it.
- Big and well equipped ambulances, but a problem connected to using them as one had to be ready for emergency use at any time, meaning that it could not always be used even for emergency transfer to higher level care.

- Ambulances owned and managed by other authority than the district health centre/the fam. practice. There seemed to be suboptimal coordination of the total ambulance services in the greater region.

Services

- The services delivered covered full treatment for some patients/professional areas that would be covered by local hospitals in Norway. F.ex. wide range of radiology and ultrasonography services, full treatment of MI and also extended chemotherapy.
- They reported regularly having problems on referral to other hospitals, even in emergency cases, because of hospital bed undercoverage, lack of specialists and probably inefficient use of nursing homes and hospital beds.
- There is no regulation by law stating that somatic hospitals are obliged to admit any patient, even in emergencies. After stabilising a patient, the doctor on call might spend much time in telephone trying to have the patient admitted.
- The Centre provided teleconsultations with specialists in hospitals, but the GP did not sit in on these consultations to learn. The centre also provided teleconsultations for cancer patients on chemotherapy, so that they could receive treatment at their local Health Centre.

Students

We didn't meet any students. The Centre representatives expressed positive attitudes to having students in community practice. They had some views on the student selection, as they had experienced that some of them were rather "old", On the other hand they often had quite extensive training before medical school, giving them both advantages in studying medicine and disadvantage in that this will represent fewer physician working years after finishing medical school.

Comparison with Norwegian systems

Our first impression was that this Health Centre was like a "mini local hospital" with regard to equipment, services and treatment offered. The family physicians have a greater scope of responsibilities than the usual family doctor in Norway. For instance will all patients with myocardial infarction be transferred to a hospital and treated by internists in Norway.

This district health centre may however be compared to some few larger Norwegian District medical centres, which practice a model of shared care or intermediate care between primary and secondary levels. In Norwegian centres of this type, there would be midwives doing deliveries. The expectant mothers due to deliver in rural areas without a gynaecological / paediatric department would go through a thorough selection process by the family physician.

We observed a familiar problem with shortage of hospital and nursing home beds. In Norway this has been tried solved by changing from having waiting lists to nursing home beds based on "first to the mill"-principle, to admittance based on an inter-professional assessment of needs, - those who have the greatest needs are admitted. The nursing homes are community owned facilities. At the same time, establishing home based services of care has been given priority in Norway. There has also been a shift of the responsibility of care from hospitals to community-based care, so that hospital beds to a lesser degree are occupied by patients that do not belong there.

In Norway there is an obligation by law for hospitals to receive and treat emergency conditions, so that they can't refuse to accept a patient sent by a district doctor. It therefore was a surprise to us that in Blind River it seemed so difficult to have such patients admitted, and that the GP had to call several hospitals and that the hospitals could turn down a request of an emergency admission

Ambulance services are in Norway owned and run by the hospitals (since 1 year ago), giving increased opportunity to local/regional coordination of the resources. By this change we also see training of the ambulance personnel being more focused.

Relevance for NCRM
This model of a rural health centre impressed us especially by being very well organised, equipped and staffed. It was also clear that the centre had health personnel competent for a wide variety of diagnostic, stabilising, and treatment functions. This makes such a centre most suitable for giving theoretical and practical training to medical students in a rural and remote setting. Norway has very few district medical centres that can be compared to this standard. But a learning lesson is that we can use those DMCs that are reasonably well organised and staffed in similar training programs as the Integrated Community Experiences at NOSM.

Summary
We are grateful for the way we were met, with hospitality, openness and willingness to use much time with us. We got an interesting glance into the dynamics of rural medicine in Canada. We have received important input in the ongoing discussion on how to develop primary health care; what is family medicine, rural/remote health care, and what and how could the NCRM work to educate the doctors that are needed in the communities and that are suited to and want to work in primary health care.

THANK YOU