community with a local maternity service in British Columbia. We then aligned the existing level of maternity service with the scores for each community and categorized a series of service levels. Further information on this method is available through our website: www.ruralmatresearch.net.

Our research interests also led us to explore another key issue underpinning rural maternity services in small communities: rural surgical services. Many, if not most, small hospital operative services are sustained by GP Surgeons and GP Anaesthetists (general practitioners with enhanced skills). With the support of GP Surgeons like Dr. Stuart Iglesias and Dr. Nancy Humber, we have begun to try and answer the core questions about the training, scope of practice, and safety of these services. Hopefully this knowledge will lead to better policies and greater sustainability for these important rural services and, ultimately, better care from rural residents.

Our most recent work has involved examining population-based outcomes by level of service for both mothers and newborns and a comprehensive examination of the cost effectiveness of various levels of service for small populations. This program of research has been undertaken with the support of the Vancouver Coastal Health Research Institute (VCHRI), which has provided us with research office space. Also, the Provincial Health Services Association (PHSA) and the Children's and Families Research Institute have provided us with support funding for programmatic grant applications. We have also had support from the Michael Smith Foundation for Health Research (MSFHR), which has provided both Dr. Kornelsen and I with scholar awards. The MSFHR has also supported the BC Rural and Remote Health Research Network, which has had its UBC base in our offices and has provided a broad range of support for rural health researchers.

As rural health services researchers, both Dr. Kornelsen and I believe strongly in the need for better evidence to support effective planning of small hospital services in rural British Columbia and across Canada. Evidence to date has largely consisted of consensus task force recommendations extolling the virtues of providing services "closer to home" without adequate evidence for issues of safety and sustainability. A systematic review of the literature relevant to the planning and sustaining of rural health services is strikingly thin with multiple lacunae related to answers to important questions such as safety and cost. Consequently, our research program has had tremendous support from the policy and planning community, including Perinatal Services of British Columbia and its antecedent organizations as well as the Health Authority Perinatal planning groups. These collaborations have ensured an integrated knowledge translation process which at times has felt like we were being pulled to deliver the answers rather than having to struggle to find someone to listen to our findings. We believe that the rural health services work that we have accomplished in the area of maternity care is directly relevant to planning other services in rural hospitals and are moving forward with plans to extend our work to studying emergency services and primary care. We believe that the University has an obligation to give back to the rural communities of British Columbia in the form of new knowledge and partnerships. We look forward to continuing our contributions in the next ten years.

> **"We believe that the University has an obligation to give back to the rural communities of British Columbia in the form of new knowledge and partnerships.**

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The Society of Rural Physicians of Canada: An Appreciation

An Interview by Dr. John Wootton

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The Society of Rural Physicians of Canada (SRPC), online at www.srpc.ca, is a child of the Internet. In the same way that email allows families to stay in touch with their children as

they disperse, so too the internet allows physicians in small towns across the country to communicate, almost in real time, about real issues with colleagues in adjacent and distant places. The Internet has created a family of rural physicians.

From the beginning of civilization, obtaining the recognition of one's peers has been acknowledged as the most important type of recognition that one can obtain. The stereotype of the "country doc" who simply does the best he can with whatever he has at hand is receding into history and being replaced by well-trained, well-equipped and multi-skilled physicians who act at the "coal face" of rural care and bring these skills to bear in the training of successive cohorts of modern rural physicians. Rural physicians now recognize the need to train and be trained by their peers because within this family of physicians are the critical attitudes and aptitudes which form the backbone of rural medicine. The conferences that the SRPC organizes, and the peer reviewed journal that it distributes, are based on this understanding: rural physicians learn best from their peers.

The history of the SRPC is linked to a job action in the emergency department of a rural hospital in the small town of Mount Forest, Ontario where rural physicians sought recognition for the unique challenges they were facing, challenges shared to a greater or lesser degree amongst all rural physicians across Canada.[1] The recognition of these unique challenges has evolved into the more general statement that "geography is a determinant of health." By this, it is meant that rural Canadians face greater risks to their health on the basis of their demographics (older, poorer, sicker), the nature of rural employment (farming, fishing, logging), and limited access to care.[2,3] And without the backdrop of the Canadian commitment to equity and accessibility in health care, the SRPC could not exist or enjoy the influence that it does. Every discussion about access to care begins with the reaffirmation of the principle that every Canadian, wherever he/she may live, deserves equitable access to care. This has never meant "equal" access, but it does require that policy makers examine what is possible and apply a "rural lens" to their decision-making.

Thus, the SRPC lobbies for change at the federal, provincial, regional, and local level.[4] Without it, the trend toward centralization, specialization, and concentration of resources could not be seen for the dangerous and insidious process that it is. The SRPC embraces issues that concern infrastructure, human resources, training, working conditions, access to services, and relationships with other organizations. More important, perhaps, is an understanding of why the SRPC exists.

> **"Every Canadian, wherever he/she may live, deserves equitable access to care.**

Every rural physician has a story. Mine goes way back to the days of rotating internships. Those were the days before collective agreements limited work hours and before I knew any better. Falling asleep over a chart at three in the morning at the end of 48 hours on-call on a medical service was a common experience as was meeting the other denizens of the night at the 24-hour vegetable stands along the Danforth in Toronto. These denizens were policemen, ambulance drivers, nurses arriving or leaving, and other assorted insomniacs. I grew comfortable with hospitals as places that were always open and always ready to help. Medical training at the time delivered a degree of procedural competence and confidence, and a variety of useful skills in a short period of time, such that by the end of one year I was champing at the bit to cut my teeth in practice. After an ill-fated locum stint in downtown Toronto that had left me crawling the walls after just one week, I went to the other extreme and signed on to be the only physician in the isolated community of Ocean Falls, located 300 miles north of Vancouver, accessible only by float plane only in good weather and only in daylight. Here, I delivered my first baby on my own, sat through a nail biting night with a suspected ectopic pregnancy, and generally grew to understand my role, both its limits and its importance, in this isolated setting. A short plane ride or a longer boat trip away, full-service general practioners were practicing in Bella Coola but in a larger hospital. From Ocean Falls I moved to Sioux Lookout in Northern Ontario, which was already a well-established rural teaching site, and benefitted from the flipped demographics of the Cree communities. I learned a lot of obstetrics, pediatrics, and the basics of collaborative care with the nurse practitioners in the north. I still meet many colleagues who are in rural practice and were lucky enough to spend some time in Sioux Lookout, or other similar places, where the experience of working shoulder-to-shoulder with like-minded colleagues has served them well wherever the ended up.

Personally, I ended up in rural Quebec, where I still take my turn on the obstetrics roster, do my share of emergency room call, in-patient care, and teaching. This is alongside the ongoing surprises of my general practice with patients I have now known for more than 25 years. I am aware, as the experience of delivering a baby whose mother I delivered becomes increasingly frequent, that a generation has passed in my rural practice. My efforts are now turning to doing my part to ensure that this new generation will also have physicians who will care for them, get to know them, become part of their communities, and benefit from the multiple ways in which these commitments are repaid.

As current president of the SRPC, my role is to do what I can to make sure the communities of rural Canada continue to have access to care which is equitable in scope, provided as close to home as possible, and delivered by a properly equipped healthcare team trained to rise to the challenges of rural practice.

That is my message. My hope is that there is a receptive audience to hear it.

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