

Reducing Interprofessional Conflicts in Order to Facilitate Better Rural Care: A Report From a 2016 Rural Surgical Network Invitational Meeting

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Résumé :

(traduction)

Le Centre sur la recherche en santé rurale a tenu une réunion sur invitation pour faciliter les discussions avec les chirurgiens généraux en Colombie-Britannique; l'objectif était de bien comprendre leurs préoccupations et traiter des questions portant sur les médecins de famille qui possèdent des compétences chirurgicales avancées (FPESS). En particulier, la réunion a porté sur les défis interprofessionnels qui nuisent à l'adoption d'un modèle de réseau entre les chirurgiens généraux et les FPESS. Ce rapport résume les conclusions ($n = 5$) et les recommandations ($n = 8$) qui ont été formulées lors de la réunion. La réunion a démontré le besoin d'avoir davantage de discussions réfléchies afin d'établir un climat de confiance et d'assurer le support interprofessionnel entre les chirurgiens généraux et les FPESS au moyen d'un système de soins de santé intégré et de réseaux adéquats.

Mots-clés :

Rural, services de santé en milieu rural, FPESS, chirurgien général, Colombie-Britannique, réseau

Abstract:

An invitational meeting organized by the Centre for Rural Health Research convened to facilitate respectful dialogue with general surgeons in British Columbia; the objective was to clearly understand concerns and address questions around rural family physicians with enhanced surgical skills (FPESS). In particular, the meeting focused on interprofessional challenges that hinder the adoption of a network model between general surgeons and FPESS. This report summarizes the findings ($n = 5$) and recommendations ($n = 8$) made during the meeting. The meeting underscored the need for more thoughtful discussions to develop interprofessional trust and support between general surgeons and FPESS through an integrated health care system and proper networks.

Keywords:

Rural, rural health services, FPESS, general surgeon, British Columbia, network

Introduction

In response to decreased provision of surgical and maternal health services in rural areas, family physicians with enhanced surgical skills (FPSS) are filling the gap by providing appropriate and effective care to rural residents (Kornelsen & Friesen, 2016; Kornelsen, Iglesias, & Woollard, 2016a; Kornelsen, Iglesias, & Woollard, 2016b). For family physicians to be certified as having enhanced surgical skills (ESS), they must first receive training at the University of Alberta, AB, Canada. The program titled “Enhanced Skills” is the only program in Canada that provides students with procedural skills training in areas such as caesarean section, endoscopy, and carpal tunnel repair. Although the ESS program is an innovative solution to the lack of surgeons practicing in rural areas, graduates of the ESS program have reported interprofessional difficulties regarding “turf wars” with general surgery colleagues that act as a barrier to the provision of necessary and appropriate care (Kornelsen et al., 2016a; Iglesias et al., 2015; Kornelsen et al., 2016b). In order to improve interprofessional relationships and reduce rural health care inequities, this invitational meeting aimed to provide a platform for general surgeons to express their concerns regarding ESS practice. Concerns identified during the event were noted and analyzed in an effort to develop a solution that is satisfying to both FPSS and general surgeons.

Background

A specialized professional culture characterized by expertise, controlled resources, and clearly set boundaries has been shown to lead to increased isolation of general practitioners (GPs) and specialists (Manca, Breault, & Wishart, 2011). Comparatively, a comprehensive professional culture characterized by the negotiation of boundaries to achieve relationship-building and effective collaboration, has been shown to contribute positively to the work culture amongst GPs and specialists. In addition, a comprehensive professional culture puts emphasis on mutual empowerment of generalists and specialists, fostering a greater level of collaboration (Kornelsen et al., 2016a; Kornelsen et al., 2016b)

Although these “turf war” conflicts seem to occur naturally in a clinical environment, studies have shown that through increased dialogue and interaction, it is possible to significantly improve interprofessional relationships. This should be encouraged as it is believed to foster mutual understanding and respect (Marshall & Philips, 1999).

Baxter and Brumfit (2008) recommend that in order to change what has traditionally been deemed “professionalism,” a whole-systems approach must be

adopted. This approach involves redefining what society views as a profession and the roles attributed to the given “profession.” The authors identified an important distinction between team identity and professional identity; the difference being that teams have important factors such as size and regular contact, that aid in creating a sense of belonging.

Within the academic literature, networks of care have been proposed as another potential solution to traditional hierarchical models (Addicott, McGivern, & Ferlie, 2010). A network of care refers to the collaboration of low-resource levels of care, secondary care, and tertiary care in the provision of health services. In essence, a referral hospital — usually secondary or tertiary care in a mid-sized city — will act as an outreach extension for rural health services that would otherwise not be sustainable (Addicott et al., 2010; Kornelsen & Friesen, 2016). The case for networks of care is rooted in the belief that with this model, knowledge can transcend boundaries. Networks have therefore been viewed as an opportunity for two-way knowledge sharing.

Using NHS Cancer Network as a case study, Addicott et al. (2010) highlighted the importance of creating a network of care. They reported that emphasis must be placed on naturally occurring relationships and an increase in support and initiatives for these relationships. Organic relationships were found to be the most successful because they are rooted in socialization and trust, which are vital to the formation of genuine communities of practice. Managed networks, which placed a higher importance on performance, were unsuccessful. It is suspected that this is because there was a significant focus on competition and following protocols which outweighed the need for knowledge exchange and the overall growth of the network to provide better care (Addicott et al., 2010). Another significant barrier to implementing a network of care is the attitudes of clinicians. In this study, clinicians frequently reported feeling that they had nothing to gain or learn from others and therefore would not participate in a network.

The objective of this Rural Surgical Network Meeting was to facilitate respectful dialogue with General Surgeons in British Columbia to clearly understand concerns and address questions around rural FPSS.

Meeting structure and purpose

An invitational meeting hosted by the Centre for Rural Health Research and in part by the Rural Coordination Centre of BC titled “Rural Surgical Networks,” took place on November 28th, 2016 in Vernon, British Columbia. The initiative consisted of subject matter experts from the Canadi-

an Association of General Surgeons (CAGS) membership and practicing rural general surgeons. The event began with a review of the meeting goals and the agenda and was followed by invited presentations and discussions.

Invitees consisted of subject matter experts and key policy stakeholders, together representing a wide range of interests. The core goal of the meeting was to clearly understand the general surgeons’ concerns about FPESS and address questions surrounding rural FPESS, in order to identify barriers that hinder the development of a rural surgical network between the two professional groups.

Two keynote presentations provided context on the history of rural health services and FPESS, as well as insight into future innovations. Following the presentations were question and discussion periods, lasting approximately 60 minutes in length. Notes taken by a scribe throughout the meeting were then summarized and synthesized by the author to develop policy-relevant findings and recommendations.

Findings and recommendations

Networks of health service delivery involving key “coaches” have been developing throughout rural Canada as a potential solution to rural health disparities, which result in part from the attrition of rural surgical and maternity services. When this model was presented to the invited surgeons, four main barriers were identified. Key findings and recommendations from the meeting participants are summarized herein and in Table 1.

Barrier 1 — The Role of Semi or Fully Retired Surgeons

Participants discussed the role of partly or fully retired surgeons taking part in the network model as potential coaches because of their increased availability compared to full-time surgeons. Key players expressed that although retired or semi-retired surgeons may have more time to commit to the network model of care, full-time non-retired surgeons are preferred and are better suited. The role of a coach is in part to connect the general surgeons to a larger network of surgeons and to be a reliable point of contact between regional referral centres. Naturally, this requires that the coach be a key player at the regional referral centre, something that would not effectively be possible with semi-retired or retired surgeons.

Barrier 2 — Unclear Role of a Coach

The participants expressed a sense of confusion regarding the role of a “coach.” It was evident from the discussions that took place that role clarification would be needed in order to move forward with a network model.

One expert expanded on his vision of the coaching role and the development that has already begun in British Columbia. He expressed that the responsibility of the coach is not to perform any sort of training, nor is it to teach general surgeons how to do procedures. Instead, it is a much-needed opportunity for general surgeons to feel supported by their colleagues. Coaches would therefore act as a support system for FPESS, to help them improve upon the things that they are already trained to do.

Table 1 Identified barriers and solutions to adopting a supportive network model based on the participants’ perspectives.

Barrier	Solution	Target decision maker (if applicable)
The role of retired or semi-retired surgeons	Have full-time surgeons act as coaches rather than retired surgeons	N/A
Unclear role of a network “coach”	Develop a clear definition and distribute it to all general surgeons	The network development team, and supported by various health authorities
The role of health authorities	Integrate health authorities in the development of a network model of care in order to initiate a change in culture and infrastructure	Health authorities throughout British Columbia
FPESS unrealistic expectations	Provide clarity to FPESS about the field of surgery in order to reduce unrealistic expectations and gain the support of general surgeons	FPESS program and its graduates
Remuneration and man power	Engage in further discussions about how the network model of care would recruit the necessary human resources and provide the general surgeons with appropriate remuneration	CAGS and the network development team

Barrier 3 — The Role of Health Authorities

In British Columbia, health services are regulated by regional health authorities. The majority of participants feel that the main obstacle to creating and implementing a network model of care does not lay with the surgeons, but rather with the regional health authorities. Work must be done to integrate the health authorities into the conversation around networks as early on as possible in order to effectively change the current culture and infrastructure. A potential first step in this area could involve the inclusion of local administrative staff and nurses in the coaching program.

Barrier 4 — FPES Unrealistic Expectations

Participants noted a concern towards unrealistic goals of general surgeons. Of the few general surgeons that the participants had dealt with, they found that more FPES hold the belief that once they have completed their training, they will be as competent as a surgeon. The event participants noted a deep concern for this type of mentality and expressed that they would require clear objectives from the network model program in order to get on board.

Barrier 5 — Remuneration and “Man Power”

As a natural follow-up to the discussions regarding the role of general surgeons in adopting the network model, subsequent discussions were held regarding what this would require in terms of remuneration and human resources. The participants were far from uniform in their opinions on the two discussion points. Some participants overtly stated the need to be compensated in monetary format for the time committed to the new model of care, while others disagreed, stating that the financial repayment would work itself out and that a larger focus should be placed on the human resources available to take-on coaching roles. It is evident that the discussion around remuneration and available human resources will require input from a larger sample of surgeons in order to draw an appropriate conclusion.

Moving forward

Rural surgical networks are an emerging potential solution to the various challenges of providing sustainable, local care in rural British Columbia. The actualization of the model is fraught with challenges inherent in low resource environments, including lack of timely access to specialist and maternal care, and difficulty maintaining competence and confidence due to low procedure volume. Findings from the invitational meeting suggest focusing on the following steps in order to enable the reduction of rural health inequities through the introduction of a rural surgical network.

1. Discuss scope of practice at the CAGS level.
2. Develop trust that is natural and instinctive by facilitating and encouraging surgeons to visit rural sites. It is anticipated that this will allow for a better understanding of the situation and resources.
3. Involve CAGS and health authorities as early on as possible in order to scale ideas and provide support.

Conclusion

The possibility of British Columbia adopting a network model of care has shed light on issues regarding privileging of FPES and general surgeons to the forefront of healthcare research as well as health policy. The 2016 Invitational Rural Surgical Network meeting focused on topics related to the concerns of general surgeons in adopting the network model and engaging as “coaches.” Realizing the potential of networks in improving rural health inequities and moving it from an idea to routine practice will involve addressing a number of important barriers. The recommendations emerging from the meeting underscore the need for more thoughtful discussions to develop the interprofessional trust and support between general surgeons and FPES through an integrated health care system and proper networks of care.

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