

**EVALUATION
OF THE
ALBERTA RURAL PHYSICIAN ACTION PLAN**

FINAL REPORT

Prepared For:

ALBERTA RURAL PHYSICIAN ACTION PLAN

Submitted By:

RPM PLANNING ASSOCIATES LIMITED

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We greatly appreciate the support we received from the RPAP administrative staff, as well as the Rural Programs Coordinator at the UofC, and the Administrative Assistant with the Rural Family Medicine & Additional Skills Training Program at the UofA.

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EXECUTIVE SUMMARY

INTRODUCTION

The purpose of this Evaluation Report is to present our key findings, conclusions, and recommendations to the Alberta Rural Physician Action Plan Coordinating Committee (RPAP CC) respecting the RPAP. It builds on the 1996 evaluation of the Alberta Rural Physician Action Plan, conducted by C.A. MacDonald & Associates.

The results of the evaluation show that although the Alberta Rural Physician Action Plan has not changed the historical pattern of specialists being concentrated in 'regional centres', such as Lethbridge, Medicine Hat, Red Deer, Grande Prairie and Fort McMurray—and Family Practitioners being located in rural communities outside of 'regional centres'—it has made a substantial contribution to the recruitment and retention of physicians to rural communities and regional centres. This has occurred, in large measure, because the RPAP initiatives have been designed to address the major factors related to rural physician recruitment and retention. In addition, several of the RPAP programs are modelled after initiatives from the United States and Australia that have proven to be effective in these jurisdictions.

For example, between 1986 and 2004, there has been an 82% increase in the number of physicians (Family Practitioners and Specialists) to Alberta rural/regional communities (from 1,045 to 1,901). During this time period there has been a 78% increase in the number of Family Practitioners to rural/regional areas (from 799 to 1,424), and a 94% increase in the number of Specialists to rural/regional communities (from 246 to 477).

Although RPAP has not explicitly attempted to target its efforts to recruit physicians to small/remote communities, the results of the evaluation show that RPAP needs to continue to work with other stakeholders to encourage graduates of the two medical schools to locate in these smaller communities, and to attract physicians from outside the province to locate in small/remote communities.

Physician recruitment and retention is multifaceted and Alberta's success in attracting and retaining physicians in rural communities and regional centres is related not only to RPAP's initiatives, but also to increases in the AHCIP Schedule of Medical Benefits, initiatives undertaken by individual RHAs, and changes in the health care delivery system in other provinces. RPM personnel used a pre/post methodology to help us determine how much of the success in the recruitment and retention of physicians to rural communities and regional centres to ascribe to RPAP.

Specifically, we undertook a comparative analysis of the data prior to the inception of RPAP and at specific points in time during RPAP's history. This allowed us to: (a) control, to some extent, for some of extraneous factors such as the major increase to the fee schedule (approximately 24%) contained in the AMA/Alberta Health and Wellness Master Agreement which covered the fiscal years 2001/02 and 2002/03; and (b) see whether the data showed any trends or only large-scale variability.

Although RPM personnel secured sufficient information to address each of the evaluation objectives (Section 1.2.1), there are some limitations to the evaluation (Section 1.2.3).

BACKGROUND

The Alberta Rural Physician Action Plan was established in early 1991 by the Alberta Government as a comprehensive action plan for the education, recruitment and retention of rural physicians. RPAP's Vision is "having the right number of physicians in the right places, offering the right services in Rural Alberta."

Its Mission is two-fold:

- offer a sequential series of initiatives in rural medical education, recruitment and retention;
- enhance collaborative partnerships.

When RPAP was first established, the RPAP's resources were focused on the education and training of the next generation of physicians and in supporting existing rural physicians through continuing medical education (CME) offerings and a rural locum service.

In the subsequent decade, the RPAP added additional supports for physician recruitment in order to address the chronic shortage of rural physicians in the province. The organization has worked with Alberta rural communities to recruit interested physicians from Canada and all around the world.

RPAP recognized that recruitment efforts alone would not provide long term solutions to the rural physician shortage in the province and, therefore, it was necessary to reform its education and training initiatives. Beginning in 2000, the RPAP implemented enhancements to its Enrichment Training Program—which included the introduction of the Skills Broker role, dedicated to arranging CME and other training opportunities for practicing rural physicians.

Physicians who had trained in urban centres, even with the decade-old RPAP rural rotations program, were not as interested or necessarily prepared to meet the broad demands of rural practice. In response to this need, the RPAP worked closely with the University of Alberta and the University of Calgary to develop the Alberta Rural Family Medicine Network—a dedicated rural-based, family medicine residency program.

After focusing its attention on the development of physician recruitment and education initiatives for the first decade, the RPAP identified that physician retention was another important area requiring attention. Initiatives were developed, beginning with a new multi-year retention work plan in 2001, to support and encourage physicians to continue to maintain their interest and commitment to rural practice. This included the development of the Rural Physician Consultant role—to support and encourage the development of recruitment and retention initiatives by physicians, rural communities and the Regional Health Authorities. It also included strengthening the Rural Physician Spousal Network (RPSN).

In 2003, the RPAP completed a review of its rural undergraduate medical education initiatives with an aim to increasing the number of rural origin students in medical school and to better support early careerists. A number of new initiatives were created and were implemented beginning in 2004/05.

Over the years RPAP has purposefully adjusted its mode of operating as shifts have occurred in its environment. Existing goals were modified and even cast aside in favour of new ones. To maintain itself as a 'learning organization', RPAP has implemented a comprehensive evaluation framework consisting of four domains:

- Key Performance Indicators (KPI) for most of its initiatives—KPIs are simply quantitative outcomes based on the overall goal and the specific objectives of a program. KPI data are used to help fine tune programming and to determine program effectiveness;
- a rolling multi-year cycle of external evaluations of its major initiatives;
- specific research studies in areas of interest that add to the understanding of new program needs and the effectiveness of current programs; and
- operational surveys which are less formal feedback mechanisms.

OBJECTIVES AND METHODOLOGY

The key objectives of the evaluation required an assessment of:

- 14 of RPAP's sequential series of initiatives in rural medical education, recruitment and retention and their impact on recruiting and retaining rural physicians; and
- the extent to which RPAP has developed collaborative partnerships with rural physicians, the Regional Health Authorities, communities, and other key stakeholders—such as the College of Physicians and Surgeons of Alberta, and the Alberta Medical Association—to support their efforts in recruiting and retaining rural physicians;
- RPAP's governance structure; and
- utilization of RPAP staff/internal consultants.

The findings included in this report are based on quantitative and qualitative information gathered from several sources. Over 170 individuals provided input during the evaluation through surveys and interviews. This included rural physicians, preceptors, medical students, the Faculties of Family Medicine at the University of Alberta and the University of Calgary, Regional Medical Directors, the College of Physicians and Surgeons of Alberta, the Alberta Medical Association, Alberta Health and Wellness, members of the RPAP Coordinating Committee, representatives of various health professions, and the RPAP Program Manager and consultants.

In addition, analysis of quantitative data provided evidence respecting RPAP's influence in the areas of rural physician recruitment and retention. This included an analysis of information from RPAP's Physician database, the Canadian Post-M.D. Education Registry (CAPER), the UofC Family Medicine Graduates Survey, and RPAP's Key Performance Indicators (KPI).

A detailed description of the methodology is provided in Section 1.2.2.

CONCLUSIONS

A. Effectiveness of RPAP on the Recruitment and Retention of Rural Physicians

1. RPAP's initiatives have been effective in contributing to the recruitment of physicians to rural Alberta. The in-migration of physicians to rural Alberta has exceeded the out-migration in almost every year since the inception of RPAP in 1991.
2. Prior to the inception of RPAP specialist physicians were concentrated in the Regional Centres primarily because they are required to deliver services at the Regional Hospitals. This historical pattern has not changed and, has been accentuated in recent years. In addition, a greater proportion of Family Practitioners have historically been located in communities outside the Regional Centres and this pattern has not changed.
3. With the exception of a one-time direct recruitment drive, undertaken at the request of Alberta Health and Wellness, RPAP's recruitment initiatives are aimed at supporting the 'direct recruitment efforts' of other stakeholders, and in establishing medical education programs, with appropriate policies, which will expose students and residents to rural medicine in an effort to encourage these individuals to choose rural medicine as a career—i.e., RPAP's education pipeline strategy.

Notwithstanding the positive contribution of RPAP's recruitment initiatives, there is an insufficient number of physicians locating in small/remote rural communities to assist the current cohort of rural physicians with the burden of meeting the health needs of their local residents. More action by RPAP, in conjunction with other stakeholders, is required to address this issue.

4. RPAP's initiatives have been effective in contributing to the retention of physicians in rural Alberta, and guiding residents to rural medicine in an effort to encourage these individuals to choose rural medicine as a career.

B. Stakeholder Perspective of the Rural Physician Action Plan

1. RPAP maintains a positive working relationship with most of its key stakeholders. It is open to new ideas and supportive of initiatives brought forth by other organizations that will enhance recruitment and retention of health care professionals. The RPAP Program Manager is considered by most stakeholders to be a great ambassador for the organization, who is hard working, thoughtful and creative.
2. Stakeholders perceive that over the years RPAP has developed some important initiatives related to rural physician recruitment and retention.
3. Some of RPAP's key stakeholders believe it is time for RPAP to become more heavily involved in 'direct' recruitment activities, leading to an increase in the supply of physicians in small/remote communities.
4. Some of the key stakeholders believe RPAP needs to change. They are of the opinion that changes in the health care delivery system, a greater emphasis on rural development, as well as changing roles of physicians and other health care professionals, require RPAP to consider thinking about how it should be positioned in the longer term—which means looking beyond its current accomplishments and thinking about how it can support the objectives of other key stakeholders in meeting the health needs of rural Albertans

C. RPAP's Governance

1. RPAP's governance model is working well and has the support of the RPAP Coordinating Committee.
2. Establishing too much oversight could stifle RPAP's ability to be innovative—a trait which is highly regarded by many of RPAP's key stakeholders.

D. Utilization of the RPAP Coordinating Committee To Address Critical Challenges

1. The RPAP Coordinating Committee is reasonably well positioned to address the identified critical challenges facing the organization respecting rural physician recruitment and retention.
2. Utilization of the Program Manager as a conduit for passing information back and forth between the Coordinating Committee and, the RPAP staff/consultants and RPAP's constituents enhances the RPAP CC's ability to develop effective responses to emerging issues, and to influence government policy.
3. One of the key strengths of RPAP is its collaboration/partnerships with a myriad of organizations. The RPAP CC should determine if there are other organizations with which RPAP should be connected.
4. The RPAP CC's approach to policy governance and its current process of establishing policy direction and executive limitations—including annual Program Manager 360° review, RPAP CC self-evaluation, approval of the three-year business plan and its annual review, the Fall budget review held prior to consideration of the new budget allocation, and the approval of the annual operational objectives—should assist the Committee in ensuring it is meeting the critical challenges it faces respecting rural physician recruitment and retention.
5. The RPAP CC should strengthen its strategic planning process.

E. Utilization of the RPAP Program Manager and Staff/Consultants To Address Critical Challenges

1. The RPAP team of staff/consultants (including the Program Manager) is well positioned to address the identified critical challenges facing the organization respecting rural physician recruitment and retention.
2. The monthly team meetings are essential in building an understanding of each other's roles. This facilitates cross-referrals and the ability to support each other's work related to emergent issues which require follow-up.
3. The Rural Physician Consultants are primarily involved in 'direct' retention activities and 'enabling' recruitment activities. None of their work involves 'direct' recruitment of rural physicians.
4. The work of the RPAP Skills Brokers in arranging for training and/or assessment of physicians adds to the supply of rural physicians.
5. The RPAP Program Manager plays a pivotal role in ensuring the RPAP team members have the necessary information and direction to meet the needs of RPAP's constituents while executing the policy developed by the RPAP CC.

F. Comparison of RPAP With the Experience of Other Countries

1. Many of RPAP's programs are similar to initiatives that are being implemented in the United States and Australia, and can be expected to be implemented in the United Kingdom.

RECOMMENDATIONS

The following is a listing of our recommendations. The body of the report includes an 'explanatory note' with most of the recommendations to guide implementation.

A. RPAP's Student Education Initiatives

RECOMMENDATION #1:

It is recommended that RPAP increase the number of Skills Days and shadowing opportunities in order that a student can participate in more than one opportunity per year, thereby keeping their interest in rural medicine high.

RECOMMENDATION #2:

It is recommended that RPAP increase its effectiveness in communicating with medical students respecting arrangements for Skills Days, hospital tours and shadowing opportunities.

RECOMMENDATION #3:

It is recommended that RPAP develop more specific expectations for the reports submitted by individuals who participate in the Summer Student Experience Program to ensure their experiences are achieving RPAP's stated objectives for this initiative.

RECOMMENDATION #4:

It is recommended that RPAP and the two universities work together to ensure most of the rural rotation preceptors dedicate sufficient time to discussing non-clinical issues of rural medicine with students and residents.

RECOMMENDATION #5:

It is recommended that RPAP and the two universities work together to ensure that a majority of students/residents participate in a rotation in a small/remote rural community.

B. RPAP's Practicing Physician Support Initiatives

RECOMMENDATION #1:

It is recommended that RPAP continue to work with the Associate Deans of the Postgraduate Medical Education at the UofC and UofA to obtain dedicated Royal College Re-entry positions available to rural physicians.

RECOMMENDATION #2:

It is recommended that RPAP either put greater effort in promoting the Rural Physician Innovation/Retention Grants Program or eliminate it and re-direct the funds to other RPAP 'physician support initiatives'.

C. Rural Physician Spousal Network

RECOMMENDATION #1:

It is recommended that RPAP implement the new conceptual framework for the Rural Physician Spousal Network including the associated work plan. This work plan should guide the work of the RSPN, as well as its management and administration. The continuation of the Network should be assessed based on the work plan by 31 March 2006.

D. Effectiveness of RPAP on the Recruitment of Rural Physicians

RECOMMENDATION #1:

It is recommended that RPAP continue to work with other stakeholders to encourage graduates of the two Alberta medical schools and medical school graduates in general to locate in small/remote Alberta communities.

RECOMMENDATION #2:

It is recommended that RPAP continue to work with other stakeholders to attract physicians from outside the province to locate in small rural/remote communities.

E. Stakeholder Perspective of the Rural Physician Action Plan

RECOMMENDATION #1:

It is recommended that RPAP convene a Round Table Discussion to examine its future direction and how it can support the objectives of other key stakeholders in meeting the health needs of rural Albertans.

F. RPAP's Governance

RECOMMENDATION #1:

It is recommended that RPAP CC continue with its regime of policy governance and its current process of establishing policy direction and executive limitations including: annual Program Manager 360° review, RPAP CC self-evaluation, approval of the three-year business plan and its annual review, the Fall budget review held prior to consideration of the new budget allocation, and the approval of the annual operational objectives.

G. Utilization of the RPAP Coordinating Committee To Address Critical Challenges

RECOMMENDATION #1:

It is recommended that the RPAP CC strengthen its strategic planning process by having a 'strategic planning retreat', using an external resource to facilitate the meeting, and reviewing relevant materials prepared by the Program Manager in advance of the retreat.

H. Comparison of RPAP With the Experience of Other Countries

RECOMMENDATION #1:

It is recommended that the RPAP Program Manager continue to examine the experience of other jurisdictions in an effort to take advantage of the lessons learned and "best practice" from elsewhere in an effort to develop innovative programs/initiatives to address the major factors affecting recruitment and retention of Alberta rural physicians.

**PURPOSE
BACKGROUND
EVALUATION OBJECTIVES
AND
METHODOLOGY**

1.0 PURPOSE

The purpose of this Evaluation Report is to present our key findings, conclusions, and recommendations to the Alberta Rural Physician Action Plan Coordinating Committee (RPAP CC) respecting the RPAP. It builds on the 1996 evaluation of the Alberta Rural Physician Action Plan, conducted by C.A. MacDonald & Associates.

1.1 BACKGROUND

Mandate of the Alberta Rural Physician Action Plan

The Alberta Rural Physician Action Plan was established in early 1991 by the Alberta Government as a comprehensive action plan for the education, recruitment and retention of rural physicians. RPAP's Vision is "having the right number of physicians in the right places, offering the right services in Rural Alberta."

Its Mission is two-fold:

- offer a sequential series of initiatives in rural medical education, recruitment and retention;
- enhance collaborative partnerships.

Origins of the Alberta Rural Physician Action Plan

As a result of chronic difficulties in physician availability in many rural and remote communities in Alberta, in early 1990, a Working Group of the External Advisory Committee on Physician Manpower was established to develop a comprehensive action plan for the recruitment and retention of rural physicians. Working Group participants included representatives from the:

- Alberta Medical Association;
- College of Physicians and Surgeons of Alberta;
- Alberta Hospital Association;
- Deans from the provincial faculties of medicine; and
- Alberta Health and Wellness.

The Working Group's plan was approved by the External Advisory Committee in March, 1990. And, Cabinet approved the plan in December, 1990.

Developed on the basis of influencing physicians' decisions about moving to and remaining in a rural Alberta community, the overall Rural Physician Action Plan as originally conceptualized comprised 16 initiatives, focused on three distinct target groups:

- (a) undergraduate medical students, post-graduate medical students (residents), the two Faculties of Medicine, and rural preceptors;
- (b) currently practicing physicians and their families; and
- (c) rural communities (and Regional Health Authorities were added in 1994/95 after regionalization).

Overview of the Alberta Rural Physician Action Plan

When RPAP was first established in 1991, the RPAP's resources were focused on the education and training of the next generation of physicians and in supporting existing rural physicians through continuing medical education (CME) offerings and a rural locum service.

In the subsequent decade, the RPAP added additional supports for physician recruitment in order to address the chronic shortage of rural physicians in the province. The organization has worked with Alberta rural communities to recruit interested physicians from Canada and all around the world.

RPAP recognized that recruitment efforts alone would not provide long term solutions to the rural physician shortage in the province and, therefore, it was necessary to reform its education and training initiatives. Beginning in 2000, the RPAP implemented enhancements to its Enrichment Training Program—which included the introduction of the Skills Broker role, dedicated to arranging CME and other training opportunities for practicing rural physicians.

Physicians who had trained in urban centres, even with the decade-old RPAP rural rotations program, were not as interested or necessarily prepared to meet the broad demands of rural practice. In response to this need, the RPAP worked closely with the University of Alberta and the University of Calgary to develop the Alberta Rural Family Medicine Network—a dedicated rural-based, family medicine residency program.

After focusing its attention on the development of physician recruitment and education initiatives for the first decade, the RPAP identified that physician retention was another important area requiring attention. Initiatives were developed, beginning with a new multi-year retention work plan in 2001, to support and encourage physicians to continue to maintain their interest and commitment to rural practice. This included the development of the Rural Physician Consultant role—to support and encourage the development of recruitment and retention initiatives by physicians, rural communities and the Regional Health Authorities. It also included strengthening the Rural Physician Spousal Network (RPSN).

In 2003, the RPAP completed a review of its rural undergraduate medical education initiatives with an aim to increasing the number of rural origin students in medical school and to better support early careerists. A number of new initiatives were created and were implemented beginning in 2004/05.

Over the years RPAP has purposefully adjusted its mode of operating as shifts have occurred in its environment. Existing goals were modified and even cast aside in favour of new ones. To maintain itself as a 'learning organization', RPAP has implemented a comprehensive evaluation framework consisting of four domains:

- Key Performance Indicators (KPI) for most of its initiatives—KPIs are simply quantitative outcomes based on the overall goal and the specific objectives of a program. KPI data are used to help fine tune programming and to determine program effectiveness;
- a rolling multi-year cycle of external evaluations of its major initiatives;
- specific research studies in areas of interest that add to the understanding of new program needs and the effectiveness of current programs; and
- operational surveys which are less formal feedback mechanisms.

1.2 EVALUATION OBJECTIVES AND METHODOLOGY

1.2.1 Evaluation Objectives

The current RPAP Three-Year Business Plan (2002 to 2005) identifies the following challenges/objectives which will guide the work of the Rural Physician Action Plan:

1. To provide physicians in training with the right skills and a sense of competence and confidence to choose rural practice as a desired opportunity, and to provide practicing rural physicians with the ability to easily obtain additional skills that will improve the standard of care in their community.
2. To make best use of existing and emerging information technologies for rural medical education, continuing medical education and clinical care in rural medical practice, and thus support distance education, and address the sense of professional isolation experienced by rural physicians.
3. To support local initiatives and develop creative programs that address innovative ideas for physician retention.
4. To support the physician and family and positively affect the factors that influence retention. As but one example, the RPAP Coordinating Committee will need to consider the findings of the upcoming "on-call syndrome" study.
5. To promote rural medicine as a viable professional career amongst rural high school students and junior medical students.

These five objectives, coupled with the seven evaluation objectives listed in the RFP provide a framework for the evaluation of the Rural Physician Action Plan. Exhibit 1 includes the key evaluation questions associated with each objective listed in the RFP.

EXHIBIT 1

EVALUATION OBJECTIVES AND SAMPLE EVALUATION QUESTIONS

Evaluation Objectives	Evaluation Questions
<p>Objective #1: To what degree have the objectives and measurable targets (where available) for the RPAP initiatives been achieved? Are there other objectives, which should be added to ensure that the overall education, recruitment and retention goals are met?</p> <p>Objective #2: Has the Rural Physician Action Plan as a whole, and/or each of its component parts, been a fundamental or contributing reason for the current level of achievement of these objectives, or have other independent factors been responsible?</p>	<ol style="list-style-type: none">1. Are there initiatives which have exceeded specified targets, and why?2. Are there initiatives which have underachieved specified targets, and why?3. Has there been a change in the environmental context which has impacted the achievement of current targets?

EXHIBIT 1 [Continued]

EVALUATION OBJECTIVES AND SAMPLE EVALUATION QUESTIONS

Evaluation Objectives	Evaluation Questions
<p>Objective #3:</p> <p>How satisfied are the RPAP's stakeholders, including rural physicians and their families, medical students and residents, Regional Health Authorities, Government, the Faculties of Medicine, the College of Physician and Surgeons of Alberta (CPSA), with the performance of the RPAP?</p>	<ol style="list-style-type: none"> 1. How does each stakeholder benefit? 2. What improvements should be made to specific initiatives to increase the benefit to the stakeholders?
<p>Objective #4:</p> <p>Are there other unintended objectives and targets, which have been achieved by the Rural Physician Action Plan (e.g. reduction of physician stress and "burnout" levels, improved quality of service, etc.)?</p>	<ol style="list-style-type: none"> 1. How does each stakeholder benefit? 2. What improvements should be made to specific initiatives to increase the benefit to the stakeholders?
<p>Objective #5:</p> <p>Are there other initiatives, in place or under consideration in other jurisdictions, which could potentially contribute to the achievement of the overall objectives more cost-beneficially? As part of an environmental scan, are there any issues that the RPAP should consider to maximize its effectiveness and the achievement of its vision?</p>	<ol style="list-style-type: none"> 1. What initiatives could be undertaken by RPAP to enhance the achievement of its vision and mission? 2. Would these "other" initiatives replace any of the current and/or planned RPAP initiatives? 3. What lessons can be learned from rural physician recruitment and retention programs in Canada and elsewhere, such as U.S., Australia, and the U.K.?
<p>Objective #6:</p> <p>Are changes to the health care system working in concert with, or in opposition to, the objectives of the Rural Physician Action Plan? How can any negative effects on overall objectives be addressed?</p>	<ol style="list-style-type: none"> 1. What is the impact of the Master Agreement regarding the Tri-Lateral Relationship And Budget Management Process For Strategic Physician Agreements? 2. What is impact of the Alberta International Medical Graduate Program? 3. What is impact of experience in the 2003 CaRMS Match which was characterized by an increased graduating class size, fewer extra positions in the Match than the previous two years, and a sharp decline in interest in family medicine—a 37% drop in the number of applicants to family medicine?
<p>Objective #7:</p> <p>To maximize the effectiveness and success of the RPAP in achieving its Vision, what changes are suggested to current RPAP programs/initiatives, responsibilities, involvement and authorities for the organization, management, monitoring and continued development of the Rural Physician Action Plan?</p>	<ol style="list-style-type: none"> 1. What initiatives could be undertaken by RPAP to enhance the achievement of its vision and mission? 2. Would these "other" initiatives replace any of the current and/or planned RPAP initiatives? 3. What changes are required in RPAP's: <ul style="list-style-type: none"> ⇒ mandate; organization; governance, roles of RPAP staff; methods for implementing strategic planning; and frequency of reporting achievement of KPI?

Fourteen of the 20 RPAP initiatives are directly included in this evaluation (see Exhibit 2). Some of the other RPAP initiatives were previously externally evaluated (i.e. ARFMN, Rural Locum Program, RPSN, Additional Skills and Enrichment Training Programs, and CME Programming for Rural Physicians). However, the findings from these evaluations were considered in reaching the overall findings, conclusions and recommendations of this evaluation. In addition, RPAP recently launched four new initiatives (Rural School Outreach, the Rural Medical School Award and Rural Medical Student Bursary, and GEMS). It is too early to include these in this RPAP evaluation.

EXHIBIT 2

RPAP INITIATIVES INCLUDED IN THE EVALUATION

Target Group	Initiative
Undergraduate Medical Students, Post-graduate Medical Students (Residents), the two Faculties of Medicine, and rural Preceptors	<ul style="list-style-type: none"> • Rural rotations for Calgary/Edmonton-based medical students and residents (CFPC and RCPSC) • Rural tours, shadowing program and rural mentoring initiative for medical students • Student summer experience program for 1st and 2nd year medical students • Matching signing bonus for practice
Currently Practicing Rural Physicians	<ul style="list-style-type: none"> • Medical Information Service • Virtual Library • Royal College re-entry positions • Rural physician retention/innovation grant program • Award of Distinction program • RuralNet
Rural RHAs and their Partner Communities	<ul style="list-style-type: none"> • Recruitment fairs • Recruitment expense reimbursement program • Community development and partnership grants • Rural Health Week

1.2.2 Evaluation Methodology

RPM personnel collected information from more than 170 individuals through focus groups and interviews (see Exhibit 3).

EXHIBIT 3
NUMBER OF STAKEHOLDERS INTERVIEWED/SURVEYED

Type of Stakeholder	Number of Stakeholders
RPAP CC, Executive and Staff	
RPAP CC Members	5
RPAP Program Manager	1
RPAP Consultants	7
RPAP Administrative Staff	3
Sub-total	16
Physicians	
Physician Survey	79
Preceptor Interviews	15
Sub-total	94
Physician Spouse Interviews	8
Physicians Accepting Signing Bonuses	7
Medical Students	
Rural Medicine Interest Groups (UofC, UofA)	11
Rural Rotation Interviews	7
Shadowing Program Interviews	6
Sub-total	24
Other Stakeholders	
Regional Medical Directors	6
Alberta Medical Association	3
College of Physicians and Surgeons	1
Alberta Health and Wellness	1
Health Organizations Participating in Rural Health Week	9
Faculties of Medicine (UofC, UofA)	3
Others (SAIT Health Sciences, UofC Faculty of Nursing, STARS, Alberta Community Development, Alberta Agriculture, Food, and Rural Development)	5
Sub-total	28
Total	177

We also reviewed relevant documents. Specifically, we:

- reviewed relevant documents such as:
 - ⇒ the 2002-2005 RPAP Business Plan,
 - ⇒ RPAP Annual Reports for 2001-2002, 2002-2003 and 2003-2004,
 - ⇒ the Action Plan for Retention of Rural Physicians (1989),
 - ⇒ Setting a Direction for Alberta's Physician Workforce (2000),
 - ⇒ the RPAP Evaluation (1996), and
 - ⇒ the evaluations commissioned by the RPAP respecting specific RPAP initiatives such as the Additional Skills Training and the Enrichment Programs (2000).
- conducted participant observations at the 2004 Recruitment Fair in Edmonton (which included some interviews with participants)
- reviewed data collected by the U of C from 3rd year (clerkship) medical students respecting their rural rotations
- conducted focus groups/interviews with:
 - ⇒ 1st and 2nd year medical students from the U of A and U of C who participate in the Rural Medicine Interest Groups,
 - ⇒ 3rd and 4th year medical students (U of A),
 - ⇒ Family Medicine residents from U of C and U of A respecting their rural rotations,
- used a survey to obtain information from:
 - ⇒ rural physicians
- conducted interviews with:
 - ⇒ rural physicians and their families,
 - ⇒ rural physicians who had participated in the RPAP Signing Bonus initiative,
 - ⇒ rural preceptors,
 - ⇒ representatives from rural communities, RPAP partners, and the RHAs,
 - ⇒ representatives from the RPAP CC, the Council of Medical Directors, Alberta Health and Wellness, the secretariat of the CPSA, the Faculties of Medicine, and the Executive of the Alberta Medical Association (AMA) Section of Rural Medicine, and
 - ⇒ all RPAP staff/internal consultants.

- obtained statistical and other information from the RPAP, such as:
 - ⇒ number of physicians in rural practice;
 - ⇒ number of physicians expected to retire in the next 5 to 10 years by skill type;
 - ⇒ trends in the number of applicants and participants for specific RPAP initiatives such as the Shadowing and Mentoring Programs, Matching Signing Bonus for Practice, the Medical Information Service and Virtual Library, and the Retention/Innovation Grants; and
 - ⇒ trends in participants/attendance at specific RPAP initiatives such as Recruitment Fairs, and Rural Health Week.
- conducted a scan of rural physician recruitment and retention programs in Canada and elsewhere, such as the U.S., Australia, and the U.K.

1.2.3 Limitations Of The Evaluation

Although RPM secured sufficient information to address the evaluation objectives, there are some limitations to the evaluation. One limitation involves comparing our findings with those noted in the 1996 evaluation of the Alberta Rural Physician Action Plan—conducted by C.A. MacDonald & Associates. We had anticipated completing a comparative analysis of the physician recruitment and retention data with the findings in the 1996 RPAP evaluation. However, due to changes in regional boundaries it was not possible to conduct this type of analysis. Instead, we re-classified the information in RPAP's physician database according to the current RHA boundaries and then applied the methodology that was used in the 1996 RPAP evaluation to calculate physician recruitment and retention rates.

Another limitation relates to the small number of some of the stakeholders. To address this limitation, we obtained information from different sources respecting the same issues. The triangulation of the data from various sources gives us strong confidence that there is corroborative evidence from which to draw appropriate conclusions.

Physician recruitment and retention is multifaceted. Therefore, a third limitation of the evaluation involves the difficulty in precisely determining how much of the success in recruitment and retention of physicians to rural communities and regional centres to ascribe to RPAP and how much to other factors and organizations that are external to RPAP. There are a variety of organizations, in addition to RPAP which have specific initiatives designed to recruit and retain rural physicians—such as the RHAs and the Alberta Medical Association. In addition, there are other stakeholders whose policies impact the supply of rural physicians such as the CPSA's licensure requirements, the government's limitation on medical school enrollment, and the medical schools' admission criteria. Thus, Alberta's success in attracting and retaining physicians in rural communities and regional centres is related to initiatives launched by RPAP and other organizations, and to external factors such as increases in the AHCIP Schedule of Medical Benefits, and changes in the health care delivery system in other provinces.

Nonetheless, we were able to address this third limitation and make solid conclusions regarding the effectiveness of the RPAP and its initiatives by using a pre/post methodology when examining the changes in rural physician recruitment and retention. Specifically, we undertook a comparative analysis of the data prior to the inception of RPAP and at specific points in time during RPAP's history. This allowed us to: (a) control, to some extent, for some of extraneous factors such as the major increase to the fee schedule (approximately 24%) contained in the AMA/Alberta Health and Wellness Master Agreement which covered the fiscal years 2001/02 and 2002/03; and (b) see whether the data showed any trends or only large-scale variability.

A fourth limitation relates to reliability of RPAP's Physician database and information from the Canadian Post-M.D. Education Registry (CAPER). RPAP's Physician database is compiled from the College of Physician and Surgeons database. The 'location' of physicians is based on self-reported information provided by the physician to the College. Accordingly, if the physician moves and does not notify the College, then the College's database will not be completely correct.

The same issue arises with respect to the CAPER data. The Canadian Post-M.D. Education Registry was established in 1986 through the co-operation of national medical organizations with an interest in the post-M.D. clinical education of physicians in Canada. An individual longitudinal file is maintained containing socio-demographic information and details of the current and past training programs of each resident or fellow under the supervision of the Canadian faculties of medicine on November 1st of each year.

While in any given year there may be some inaccuracies in each of these two databases, the longitudinal trends in the in/out migration of physicians to rural and regional communities show a consistent picture. Because of this consistency, we believe the information from RPAP's Physician database and the Canadian Post-M.D. Education Registry is sufficiently reliable to support the conclusions drawn in the evaluation.

A fifth limitation concerns our attempt to undertake a comparative analysis of Alberta's experience in recruiting and retaining rural physicians with that of Saskatchewan and British Columbia. Regrettably, Alberta is the only province that collects information, on an ongoing basis, about 'physician location'. We attempted to obtain relevant data from B.C. Health and Saskatchewan Health and the Canadian Institute for Health Information (CIHI). However, the available data was for 'total' physician counts only, rather than for 'rural', 'regional' and 'urban' communities. We were able to obtain some literature related to the number of rural physicians in British Columbia between 1998 and 1999.

The 'working conditions' in other provinces must also be considered when trying to assess RPAP's contribution in physician recruitment and retention. That is, some rural-based physicians from elsewhere in Canada may have been influenced to come to Alberta because of perceived negative changes in the health care delivery system of their home province. Regrettably, we have no data related to this particular factor and the role it may have played in recruiting physicians from other provinces.

**RURAL PHYSICIAN RECRUITMENT
AND RETENTION:
LESSONS FROM THE LITERATURE**

2.0 INTRODUCTION

To evaluate RPAP's recruitment and retention initiatives/programs it is important to understand the issues and driving forces that led to the initiation of these programs and shaped their design. We have reviewed the literature related to rural physician recruitment and retention and our findings are presented in the next several paragraphs.

2.1 RURAL PHYSICIAN RECRUITMENT AND RETENTION: LESSONS FROM THE LITERATURE

Recruitment and retention of rural physicians has been a significant challenge globally for more than two decades. Numerous researchers have identified the driving and restraining forces related to the recruitment and retention of rural physicians. Their findings, which provide a backdrop for assessing the effectiveness of RPAP's initiatives, are presented in this section of the evaluation report.

A. Recruitment of Rural Physicians: What Do We Mean By Recruitment?

Before discussing the findings from the literature it is important to define the term 'recruitment'. According to the dictionary, recruitment refers to the process of finding possible candidates for a job or function. Applying this definition to the 'recruitment' of rural physicians' means that someone is taking action to find physicians who would be interested in practicing in a rural community.

The literature uses the term 'career choice' as being synonymous with 'recruitment'. That is, when discussing the issue of 'physician recruitment' a substantial number of researchers report that their surveys included questions about the 'choice of medical field' and 'location of practice'. Often when researchers present the percentage of respondents who chose to practice medicine in a rural location, they list the key factors which contributed to this decision. They frequently list these factors as critical determinants associated with 'recruiting' physicians to practice in a rural community.

However, it is important to distinguish between increasing the supply of rural physicians through active recruitment versus enhancing the possibility of medical students and residents choosing rural-based practice. Although the literature does not always clearly distinguish between the two strategies, the distinction is critical when trying to assess the effectiveness of RPAP's recruitment initiatives.

When examining the issue of physician recruitment, it is also important to consider the 'choice of medical field' as a key variable—i.e., distinguishing between the 'type of practitioner' that is being recruited, such as:

- General/Family Practitioners—i.e., physicians involved in the delivery of primary care;
- General/Family Practitioners with a specialty—i.e., FP Anaesthetists and GP Surgeons; and
- Specialists, including Anaesthetists, Paediatricians, Obstetricians, Urologists, Psychiatrists, and General Surgeons.

B. Recruitment of Rural Physicians: Findings From The Literature

Woodward and Ferrier (1982)¹ conducted a survey of students who graduated from McMaster University's medical school between 1972 and 1977. The authors reported that climate and geography, preference for urban or rural living, and influence of spouse were the factors that most influenced the location of practice. Almost half of the 318 graduates chose primary care (15% general practice, and 31% family practice). Approximately one-third of the graduates who had chosen 'primary care', made this decision **before** entering medical school, and a similar percentage had made their choice **during** medical school.

Leonardson and colleagues (1985)² surveyed a total of 182 medical students who graduated from the University of South Dakota School of Medicine between 1969 and 1973. They found that physicians who grew up in a rural community were more likely to practice in a rural setting. Moreover, the physicians tended to locate in communities of a similar size to where they and their spouse grew up. Another notable finding from their work was that rural-based physicians made their decision about where to practice early in their medical training.

A survey of 159 physicians who graduated from the Family Medicine Program at Queen's University, Kingston, Ont., between 1977 and 1991 conducted by Easterbrook et al. (1999)³ revealed that physicians who were raised in rural communities (population <10,000) were 2.3 times more likely than those from non-rural communities (population >10,000) to choose to practice in a rural community immediately after graduation. They were also 2.5 times more likely to still be in rural practice at the time of the survey. Easterbrook and his colleagues also found no association between exposure to rural practice during undergraduate or residency training and choosing to practice in a rural community.

When Rabinowitz and his colleagues (1999)⁴ analyzed information for 1972 to 1991 graduates of the Jefferson Medical College, using data from the Jefferson Longitudinal Study, they found that 'rural background' was the most important independent predictor of rural practice, and entering medical school with plans to become a family physician was the only other independent predictor of rural practice. No other variable, including curriculum or debt, added significantly to the likelihood of rural practice.

Rabinowitz and his colleagues reported that their results are also consistent with the self-reported perceptions of Jefferson graduates practicing in rural areas, who indicated that the major reasons they chose to practice in a rural community were related to "area lifestyle issues or because they grew up in a similar area (76%)." In addition, 64% of these rural graduates reported that "their spouses had grown up in rural areas."

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1. Woodward, C.A., Ferrier, M., Career development of McMaster University medical graduates and its implications for Canadian medical manpower. CMA 1982; 127 (15): 477-480.
 2. Leonardson, G, Lapierre, R., Hollingsworth, D, Factors Predictive of Physician Location. Journal of Medical Education 1985; 60: 37-43.
 3. Mark Easterbrook, M, Marshall, G, Wilson, R, Hodgetts, G, Brown, G, Pong, R, Najgebauer, E, Rural background and clinical rural rotations during medical training: effect on practice location. CMAJ 1999: 160 (8) 1159-63.
 4. Rabinowitz, H, Diamond, J.J, Hojat, M, Haxelwood, C.E, Demographic, educational and economic factors related to recruitment and retention of physicians in rural Pennsylvania. Journal of Rural Health 1999: 15 (2) 212-218.

Wetmore and Stewart (2001)⁵ found from their 1997 survey of 247 second-year residents enrolled in a family medicine training program in Ontario, that residents who received at least some rural training were more likely to choose a non-urban practice location than residents who did not receive rural training. They also reported that residents with some rural training were significantly more confident in both ambulatory-care and emergency procedures compared to residents without rural training. Wetmore and Stewart concluded their findings support a recommendation for “increased rural training opportunities in family medicine residency to increase the number of residents who ultimately choose a rural practice location.”

Woloschuk and Tarrant (2002)⁶ also investigated whether a rural educational experience influenced medical students' likelihood of rural practice. The RPAP-funded family medicine clerkship at the University of Calgary is a 4-week mandatory rotation in the final year of a 3-year medical school program. Clinical clerks from five consecutive classes (1996 to 2000), who trained at rural sites, responded to questionnaire items both before and after the rural educational experience. Pre/post questionnaire data were available for 254 students and the analysis revealed that although a pre/post increment in the 'likelihood of rural practice' was not observed, students stated they are 'more likely to do a rural locum' as a result of the rural educational experience. The authors surmise that at this stage in their training, students may not be ready to commit to the demands of rural practice.

As part of their research, Woloschuk and Tarrant examined the impact of 'student background'. They found that “rural background students were significantly more likely than their urban peers to do both a rural locum and to practice in a rural community.” However, they point out that “few applications to medical schools come from candidates who are raised in rural areas, leading to an under-representation of rural individuals in incoming medical school classes.”

Dhalla et al. (2002)⁷ also found that certain socioeconomic and demographic groups are under-represented in Canadian medical schools. In early 2001, they conducted a survey of first-year medical students to obtain information about their age, gender, self-described ethnic background, and postal code at the time of high school graduation. Responses were compared, when possible, with Canadian age-group-matched data from the 1996 Canada census. These researchers found that “Canadian medical students are not representative of the Canadian population. That is, medical students are much more likely than the general population to come from urban areas, neighbourhoods with high median family incomes, and be children of well-educated, professional parents.” They found that there were less than half as many students from rural backgrounds as one would expect from the Canadian population.

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5. Wetmore, S.J, Stewart, M, Is there a link between confidence in procedural skills and choice of practice location? Canadian Journal of Rural Medicine 2001: 6 (3) 189-194.
 6. Woloschuk, W, Tarrant, M, Does a rural educational experience influence students' likelihood of rural practice?: Impact of student background and gender. Medical Education 2002: 36 241-247.
 7. Dhalla, I.A, Kwong, J.C, Streiner, D.L, Baddour, R.E, Waddell, A.E, Johnson, I.L, Characteristics of first-year students in Canadian medical schools. CMAJ 2002: 166 (8) 1029-1035.

Woloschuk, Crutcher, and Szafran (2005)⁸ identified 'non-clinical' factors that influenced graduates of the family medicine residency programs at the universities of Alberta and Calgary to choose rural practice. The authors point out that their work "is among the first to examine what non-clinical preparation for rural practice may entail."

Using a 4-point scale, graduates rated the extent to which the residency program prepared them for eight dimensions of rural practice:

- clinical demands of rural practice;
- understanding rural culture, small community living;
- balancing work and personal life;
- establishing personal/professional boundaries;
- becoming a community leader, handling a 'fish bowl' lifestyle; and
- choosing a suitable community.

Factor analysis of their survey data from 282 respondents produced two factors 'rural culture' and 'rural community leader'. "Rural culture' appears to reflect the core of the small town way of life and includes the clinical demands accompanying rural practice such as workload, hours and call. 'Rural community leader' takes into account the leadership expectations and multiple roles of being a rural physician. Rural community leadership challenges include self-management of lack of anonymity as someone 'under the magnifying glass', and matching one's needs, interpersonal style and priorities to a suitable community."

Woloschuk, Crutcher, and Szafran found that "family medicine graduates who felt prepared for the role of a rural community leader were nearly twice as likely to be engaged in rural practice." They also identified 'rural background' as a variable predictive of rural practice.

Geyman et al. (2000)⁹ conducted a comprehensive literature search and content analysis to identify and evaluate the interventions used to increase the supply of rural physicians. They created the following categories of initiatives:

- Medical student selection, recruitment and retention;
- Predoctoral medical education;
- Graduate medical education;
 - ⇒ Location of residencies
 - ⇒ Rural training tracks
 - ⇒ Fellowships
- National Health Service Corps; and
- State programs.

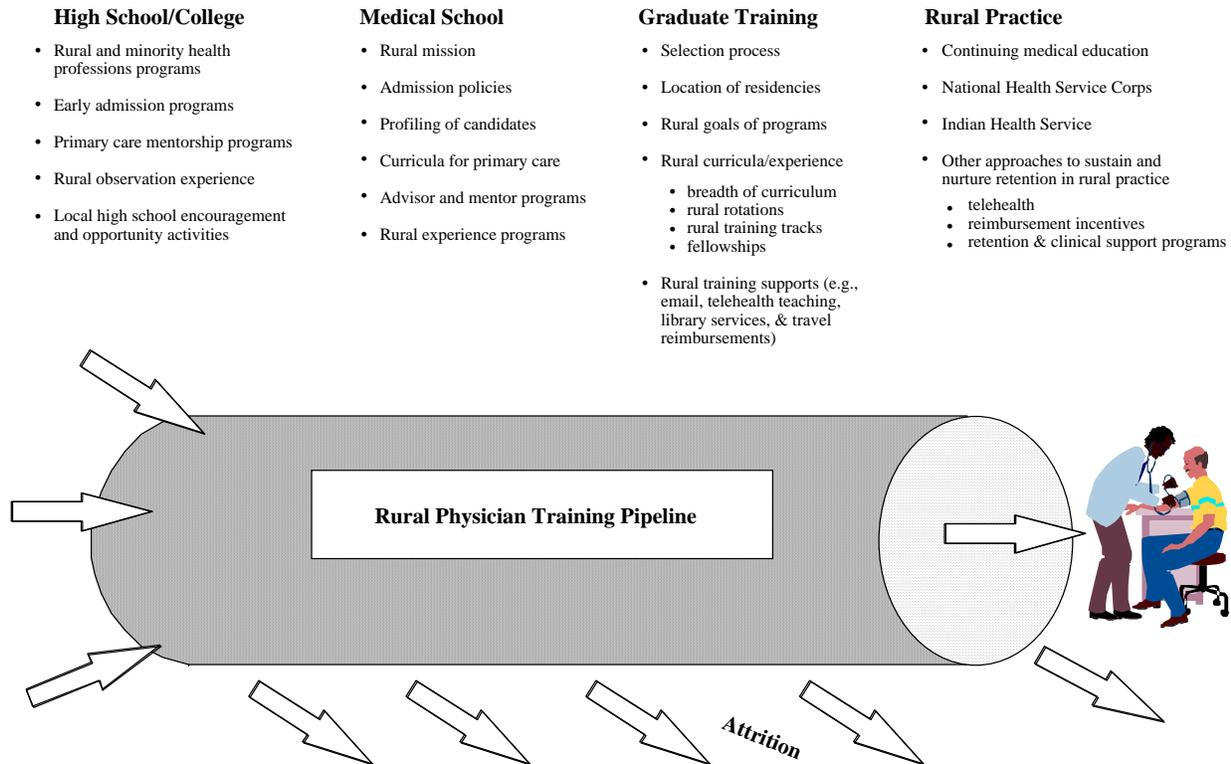
8. Woloschuk, W, Crutcher, R, Szafran, O, Preparedness for rural community leadership and its impact on practice location of family medicine graduates. Australia Journal of Rural Health 2005: 13 3-7.

9. Geyman, J.P, Hart, G, Norris, T.E, Coombs, J.B, Lishner, D.M, Educating generalist physicians for rural practice. Journal of Rural Health 2000: 16 (1) 56-80.

Geyman et al. suggested that these initiatives can be thought of as a 'pipeline continuum' (see Exhibit 4).

EXHIBIT 4

PHYSICIAN EDUCATION AND RURAL LOCATION: A PIPELINE CONTINUUM



Based on their analysis of the collected information Geyman et al. reported that the pipeline for prospective rural physicians starts well before medical school. They identified that 'rural background' and an 'interest in family practice' are critical variables that should be explicitly targeted by medical school admission committees.

Geyman et al. also noted that providing rural physicians with a broad range of knowledge and skills requires a "strong rural mission and sufficient immersion in rural training settings." This can be aided by implementing a comprehensive curriculum and using medical informatics and telemedicine to remove communications and knowledge barriers between rural and urban programs.

These authors conclude by saying that the educational pipeline to preparing physicians for rural practice is both long and complex, with many opportunities for attrition all along the way from high school to rural practice. Many factors have been found to be associated with the extent to which educational programs can cause rural physicians to emerge at the end of the educational pipeline, including:

- rural mission of the program;
- credible mentoring by faculty;
- types of rural educational experiences;
- the background of students and residents; and
- desires of their partners/spouses.

According to the literature, 'recruiting' rural physicians can be effectively accomplished by influencing the factors involved in a student's career choice. It begins by encouraging high school students in rural communities to choose a career in medicine, extends to ensuring medical schools include 'rural background' as one of their selection criteria and providing undergraduates and residents with training opportunities in rural settings to maximize their exposure to rural practice and rural living. The literature articulates that addressing these and other issues are likely to produce physicians who will choose to be engaged in rural practice.

C. Retention of Rural Physicians: What Do We Mean By Retention?

Discussing 'physician retention' requires one to define what we mean by 'retention' and 'rural' because the factors affecting decisions to stay/leave may be different depending on the size of community or the 'rurality' of the practice location. The literature classifies 'physician retention' in the following ways:

- physicians who stay in their original rural community are considered to be 'stayers';
- physicians who leave their rural community to practice in a nonrural setting are considered to be 'leavers'; and
- physicians who leave their original rural community and move to another rural location may be considered to be 'leavers' because communities want 'long-term continuity' with their physicians, and if a physician relocates anywhere else (rural or nonrural) it is considered to be a loss.

The discussion of 'physician retention' is further complicated because of the need to classify communities as either 'rural' or 'nonrural'. It is necessary to use an agreed upon definition of 'rural' when examining physician relocation.

Woloschuk, Crutcher, and Szafran (2005)¹⁰ note that there are accepted definitions of rural and urban practice in Canada. Communities with a population <10,000 are classified as rural, and those centres with a population ≥10,000 are considered to be urban. It could be argued that this definition of 'rural' is too large to examine retaining physicians in 'small/remote' rural communities in Alberta such as Spirit River (population of 1,100) and Milk River (population of <900)—recognizing that these communities serve a larger catchment population.

In Alberta, there are two metropolitan centres—Calgary and Edmonton. Sometimes physicians have been classified as 'rural' if they practice outside the metropolitan centres. There is no universal acceptance of this definition.

In addition, the cities of Medicine Hat, Lethbridge, Red Deer, Grande Prairie, and Fort McMurray each have a regional hospital which provides tertiary and secondary level care. These communities are classified as Regional Centres. Sometimes physicians who practice in these Regional Centres are classified as 'rural' because they serve the 'surrounding rural communities'. However, the more recently accepted practice is to include 'Regional Centre' as a separate category, rather than classifying them either as rural or nonrural.

It is also accepted practice to classify the 'bedroom communities' in close proximity to the cities of Calgary and Edmonton as a separate category. This includes the communities of Airdrie, St. Albert, Sherwood Park, and Spruce Grove.

10. Woloschuk, W, Crutcher, R, Szafran, O, op cit.

D. Recruitment of Rural Physicians: Findings From The Literature

Cutchin et al. (1994)¹¹ surveyed 132 primary care physicians in rural Eastern Kentucky and found the following factors to be either 'very important' or 'considerably important' to physician retention:

- availability of relief coverage;
- quality of local schools;
- compatibility with the medical community;
- availability of quality housing;
- consultation with a specialist via telephone; and
- availability of practice partners.

In addition, Cutchin and his colleagues found that retention is related not only to professional concerns, but also to the physician's sociocultural integration in the community. The latter relates to understanding the linkages between the physician as person, family member, professional, and community member. They indicated that "responses to the open-ended survey question depicts an intricate mosaic of community integration by stressing concepts such as:

- acceptance/support of or compatibility with community;
- recreational opportunities;
- spouse's economic/social/cultural happiness;
- physician access to family; and
- religious support structure.

The findings of Bowman, Crabtree, Petzel, and Hadley's findings are similar to those of Cutchin et al. In a purposeful sample of 10 established rural physicians from counties of <10,000 people, Bowman and his colleagues (1997)¹² found that successful practice situations seem to involve:

- having enough physicians to be able to handle the workload;
- having a balance between the physicians and the number of available patients;
- working cooperatively with others to improve the local health system while managing individually to build a viable practice; and
- providing as much availability to patients as possible while attempting to maintain an acceptable level of personal and family emphasis.

Brown et al. noted that "in small systems, the individual has a great deal of impact and individual initiative is critical. Building a practice may be an important marker for this individual initiative. The other side of the coin is cooperation. The balance between individual initiative and cooperation in small rural health systems may be so precarious that all components (providers, administrators, and community leaders) must succeed both individually and collectively for success in rural health care."

11. Cutchin, M.P, Norton, J.C, Quan, M.M, Bolt, D, Hughes, S, Lindeman, B, To stay or not to stay: Issues in rural primary care physician retention in Eastern Kentucky. *Journal of Rural Health* 1994: 10 (4) 273-278.

12. Bowman, R.C, Crabtree, B.F, Petzel, J.B, Hadley, T. S, Meeting the challenges of workload and building a practice: The perspective of 10 rural physicians. *Journal of Rural Health* 1997: 13 (1) 71-77.

Building on his earlier work, Cutchin (1997)¹³ takes the perspective that integration of physicians within rural communities is the basis for retention. He postulates that three domains—the physician self, the medical community, and the community-at-large—and their constituent elements, should be considered when studying the integration of physicians or other practitioners in rural areas.

Exhibit 5 presents the generalized dimensions of the rural physician self, the medical community and the community-at-large distinguished during Cutchin’s research process. He notes that the three domains are universal across integration situations, but the combination of dimensions that make up each domain will vary across cases.

EXHIBIT 5
DOMAINS OF INTEGRATION AND COMPONENT DIMENSIONS

Physician Self	Medical Community	Community-at-Large
Historical Self Socioeconomic background Previous rural experience Role models and mentors Family background and support Graduate medical education experience	Institutions Hospitals Practice structures Size and power of institutions Role of extra-local players Historical development	Social Rurality and extra-local ties Sociocultural milieu Social networks and cohesion Class divisions
Social Self Social group affiliation Immediate family Roles to fill Institutional membership Community setting Present cultural mix	Physicians Demographics Medical ideologies Level of cooperation, communication, and interaction Number of physicians Anchorpersons Types of innovation	Economic Current development efforts Resources available (people, institutions, financial, knowledge)
		Political Political institutions and leadership Level of citizen involvement in affairs Ability to see possibilities
Emergent Self Values Aspirations Strength of identity Creativity		Other Historical development Geographic coherence

In another research paper, Cutchin (1997)¹⁴ provides a theoretical perspective on retention called “experiential place integration.” He notes that “within ‘place’, there are large-scale events or transactions that envelope us and often constrain us; there are interpersonal or group interactions, and; there are relatively autonomous self actions. The interlocking and continuous set of actions creates a situation of emerging experience.

This perspective creates a focus on the connection and interaction between physicians and their local settings. For example, Cutchin points out that ‘place integration’ will be affected by culture, economics, politics, gender, and other components of experience. This dynamic relationship affects physician decision-making related to staying or leaving a community.

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13. Cutchin, M.P, Community and self: Concepts for rural physician integration and retention. Social Science and Medicine 1997: 44 (11) 1661-1674.
 14. Cutchin, M.P, Physician retention in rural communities: the perspective of experiential place integration. Health and Place 1997: 3 (1) 25-41.

Cutchin's concept of 'experiential place integration' is reflective of the work of undertaken in the late 1800s early 1900s of Frédéric Le Play and Patrick Geddes. Le Play had developed an approach to the study of societies which encompassed three factors: Place, Work, Folk. Geddes used this typology and applied it to city planning. Both men described societies in terms of the constant interaction of these three factors. That is, mutual relationships develop between the society (folk), community (place), and (economics) work factors—they influence each other quantitatively and qualitatively. This is somewhat analogous to Cutchin's 'experiential place integration'.

Cutchin notes there are three primary principles which characterize the place integration process—security, freedom and identity—and their component dimensions (see Exhibit 6). He states that these principles express more than simple 'motives' which drive physician action and integration with the community, resulting in decisions to either stay or leave the community. They denote both the types of ongoing problems faced and the solution derived by rural practitioners during the process of integration.

EXHIBIT 6

DIMENSIONS OF SECURITY, FREEDOM AND IDENTITY

Dimensions of Security	Dimensions of Freedom	Dimensions of Identity
Confidence in medical abilities	Challenge and diversity in medical work	Loss of anonymity
Commitment to aspirations and goals	Ability to consult more with patients	The "like-minded" practice group
Ability to meet family needs (spouse's happiness, education)	Cooperation within the medical community	Roles played and responsibilities taken
Comfort with medical community and institutions	Cooperation within the community-at-large	Respect of the medical and at-large community
Degree of on-call coverage	Respect of the medical and at-large community	Fulfilling aspirations in place
Practice group environment and the anchorperson	Power in medical relations	Seeing the self as belonging to community
Community and medical institution development	Ability to develop health care resources	Awareness of self in time and place
Social and cultural networks available	Diversity in social interaction possibilities	Creation of future goals in place
Respect of medical and at-large community	Involvement in community affairs	
	Personal and family activities	
	Developed perspective on self and place	

Rabinowitz et al. (1999)¹⁵ conducted a comparative analysis of physicians who remained in rural practice for between 5 and 10 years, with their peers who moved to nonrural areas. They found that none of the variables that were predictive of practicing in a rural area—including rural background—was related to retention. Rural respondents indicated the following reasons why they had difficulty retaining physicians in their own practice—many of which are similar to Cutchin's findings:

- area lifestyle issues;
- reimbursement issues;
- personality and practice conflicts; and
- the heavy workload.

15. Rabinowitz, H, Diamond, J.J, Hojat, M, Haxelwood, C.E, Demographic, educational and economic factors related to recruitment and retention of physicians in rural Pennsylvania. op cit.

Sempowski, Godwin, and Seguin (2002)¹⁶ conducted a cross-sectional survey of physicians who had been practicing in one rural Ontario location but left after less than 3 years (“short term” physicians) and those physicians who practiced more than 7 years in the same rural Ontario location (“long term physicians”). The short term group consisted of those who had moved to another rural location and a subgroup of physicians who had moved to a nonrural location. Their findings are consistent with those of other researchers and Sempowski et al. suggest that future research related to rural physician retention should include an examination of:

- spousal contentedness;
- child-related issues; and
- social isolation.

According to the literature, ‘retention’ is not an ‘event’, but rather a ‘dynamic process’ involving the physician, his/her spouse and family, his/her colleagues, the medical environment (including attitudes of local health authorities), the community-at-large, and community leaders. These factors are interrelated and, over time, a change in one may trigger a change in others. How the physician integrates these changes will impact his/her decision to stay or leave the community. The lesson from the literature is that ‘physician retention’ is an ongoing process which requires monitoring in order to identify emerging issues which require intervention/resolution in an effort to strengthen a physician’s desire to stay in the community.

16. Sempowski, I.P, Godwin, M, Seguin, R, Physicians who stay versus physicians who go: Results of a cross-sectional survey of Ontario rural physicians. Canadian Journal of Rural Medicine 2002: 7 (3) 173-179.

**EFFECTIVENESS OF RPAP'S INITIATIVES:
FINDINGS
CONCLUSIONS
RECOMMENDATIONS**

3.0 INTRODUCTION

The Mission of the Alberta Rural Physician Action Plan is two fold: (1) to offer a sequential series of initiatives in rural medical education, recruitment and retention; and (2) to enhance collaborative partnerships. RPAP is currently implementing more than 20 initiatives, many in collaboration with other organizations, to achieve its Vision of “having the right number of physicians in the right places, offering the right services in Rural Alberta.”

This section of the report evaluates the effectiveness of 14 RPAP initiatives:

- Rural tours and shadowing program initiative for medical students
- Student summer experience program for 1st and 2nd year medical students
- Rural rotations for Calgary/Edmonton-based medical students and residents (CFPC and RCPSC)
- Recruitment fairs
- Matching signing bonus for practice
- Medical Information Service
- Virtual Library
- Royal college re-entry positions
- Rural physician retention/innovation grants
- Award of Distinction program
- RuralNet
- Recruitment expense reimbursement program
- Community development and partnership grants
- Rural Health Week

To evaluate these initiatives RPM personnel obtained information from various sources—including rural physicians and their spouses, preceptors, medical students and residents, Regional Medical Directors, the Alberta Medical Association, the College of Physicians and Surgeons of Alberta, the Faculties of Medicine at the University of Calgary and the University of Alberta, the RPAP Coordinating Committee, the RPAP consultants and administrative staff, and others. We also reviewed relevant statistics and documents.

3.1 OVERVIEW OF RPAP RECRUITMENT AND RETENTION INITIATIVES

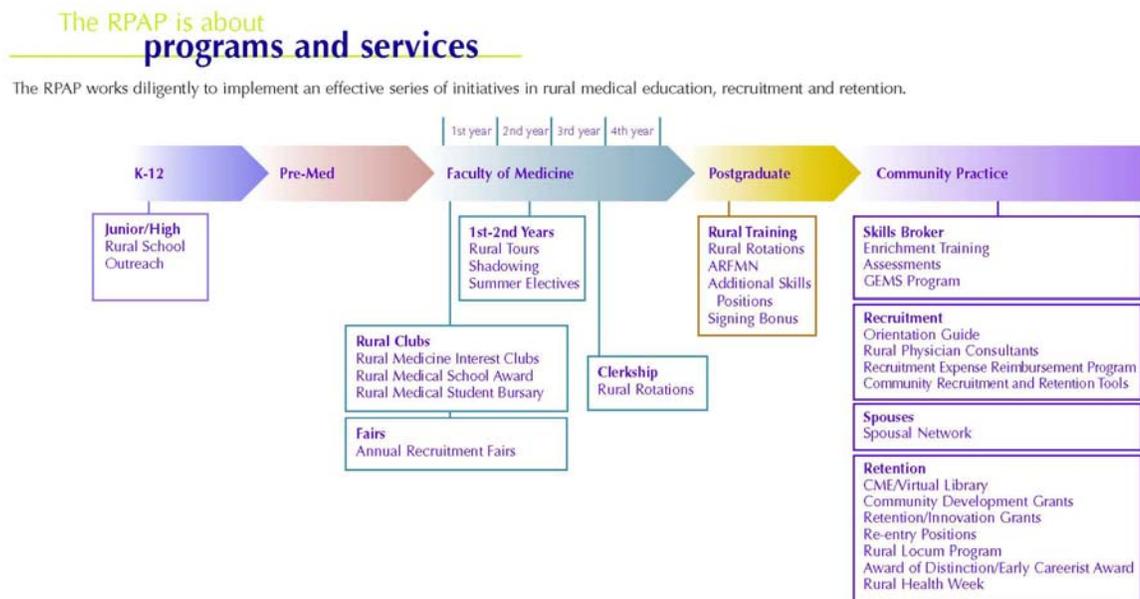
As illustrated in Exhibit 7, RPAP has established a ‘pipeline continuum’ of recruitment initiatives. The strategy behind the ‘educational pipeline’ is to expand the supply of rural physicians by increasing the pool of students who are interested in rural-based practice. This begins with exciting rural junior and senior high school students to consider a career in rural-based medicine and continuing to build and maintain that interest in the undergraduate and clerkship years of medical school, culminating in the selection of rural residency training. Geyman and his colleagues point out, however, that “the educational pipeline to rural medical practice is long and complex, with many places for attrition along the way.”

RPAP has also established initiatives designed to assist communities and Regional Health Authorities to find and recruit physicians who would be interested in practicing in a rural community.

In addition, Exhibit 7 summarizes RPAP’s ‘retention’ initiatives. They are consistent with best practices identified in the literature and focus on four critical areas:

- finding ways of addressing issues/concerns from physicians’ spouses so that they feel comfortable with rural living;
- training to ensure rural physicians feel confident and comfortable in addressing the health needs of their communities;
- relief from the heavy workload associated with rural practice; and
- recognition of the contribution of rural physicians to their profession and their communities.

EXHIBIT 7 SEQUENTIAL SERIES OF RPAP INITIATIVES



RPAP's team of contract staff/consultants are responsible for working with partner organizations and rural communities to implement these initiatives. This team includes the Program Manager, two Rural Physician Consultants, two Skills Brokers, the Research Consultant, the Medical Students' Initiatives Coordinator, and the Communications Consultant, as well as administrative staff.

3.2 RPAP'S STUDENT EDUCATION INITIATIVES

This section presents our findings and conclusions respecting the following RPAP student education initiatives:

- Rural tours and shadowing program initiative for medical students;
- Student summer experience program for 1st and 2nd year medical students;
- Rural rotations for Calgary/Edmonton-based medical students and residents (CFPC and RCPSC);
- Recruitment fairs; and
- Matching Signing Bonus.

3.2.1 Findings: RPAP's Student Education Initiatives

A. Rural Tours and Shadowing Program For Medical Students

Description of the Rural Tours

A 'rural tour' consists of two components—a Skills Clinic and a hospital tour. During the Skills Clinic local health care professionals teach students specific procedural skills such as starting IVs, casting and suturing. Medical students attend these clinics to learn basic medical skills taught by rural physicians and other health care professionals. In 2004/05, a total of 124 medical students from UofC and UofA participated in a 'rural tour'.

The hospital tour typically includes guest speakers as well as a tour of the local hospital. There may also be an EMS in-service and scenarios as well as presentations by fire/search and rescue.

Typically, there is a trip to a local attraction. This is designed to provide students with an understanding of the attractive features of the local area.

Description of the Shadowing Program

The shadowing program was developed after talking to participants on the medical student rural hospital tours. These students felt that they would not get enough exposure to rural medicine in their early medical school education. The shadowing program is an attempt to increase the rural experience of early careerists by having medical students follow rural physicians for a weekend on call. This gives them another opportunity to see what rural medicine has to offer. Hopefully, this exposure will generate future and continued interest in rural medicine. There are approximately 50 rural sites involved with over 150 physicians who are willing to have a medical student shadow them for all or part of a weekend. The response from the preceptors and the medical students who have participated to date has been very positive. In 2004/05, a total of 71 medical students from UofC and UofA participated in the 'shadowing program'.

Effectiveness of the Rural Tours and the Shadowing Program

The rural tours (Skills Clinic and hospital tours) and shadowing program were started in September 2002 and are arranged by the Medical Students' Initiative Coordinator and Rural Medical Interest Group student representatives. The primary objectives of these initiatives are two-fold:

- expose first and second year medical students, early in their medical school education, to rural-based practice; and
- excite medical students about rural medicine as a way of increasing the possibility that they will choose rural-based practice as a career.

To assess the effectiveness of the rural tours and shadowing program in meeting these objectives, RPM personnel conducted focus groups with medical students at both the University of Calgary (3 individuals) and the University of Alberta (9 individuals). We also conducted interviews with six students who had attended a 'rural hospital tour' and who had participated in the 'shadowing program'. These data collection activities took place between January and February 2005.

RPM personnel also attempted to arrange an interview with several physicians who participate in the rural tours and shadowing program in order to obtain their perspective of the value of these initiatives and whether any improvements should be made to increase their effectiveness. However, due to their heavy workload, none of these physicians accepted our offer.

During our focus groups with medical students from both universities, we learned that the Skills Clinic provides 'real-world' exposure to rural medicine which allows the students to practice specific skills such as suturing, casting, intubation and setting IVs. This experience excited students about rural medicine as they began to understand that rural physicians require an extensive array of clinical skills and competencies in order to meet the varied demands of their patients. The students reported that this exposure bridged their lecture experience with the real-world demands of rural-based medicine.

The medical students who attended the focus groups reported they valued the 'hospital tour' and indicated they benefited by being exposed to the:

- way the physician and other health care providers support each other in meeting patient needs;
- fact that the hospital had up-to-date equipment to support the work of the physician and other health care professionals; and
- stature of the rural physician within the hospital setting.

During our interviews with six of the medical students who had participated in the 'shadowing program' in 2004/05, most reported that they were motivated to register for this initiative because they are quite interested in rural medicine and they wanted the clinical exposure. All six of these medical students stated they wanted to see what rural medicine was really like.

During the weekend shadowing the preceptor, half of the six medical students had the experience of examining patients, while two-thirds reported the preceptor permitted them to assist with procedures. The experiences enhanced the value of the shadowing initiative for these individuals.

Half of the six medical students we interviewed noted that during their shadowing weekend they interacted with the physician's family. Two of the three students reported that they had been invited to the physician's home. This provided the physician and his/her spouse with an opportunity, in a relaxed setting, to discuss the challenges and the benefits of rural living and rural practice.

The medical students we interviewed indicated the physician and/or his/her spouse pointed out that ***the most critical challenge in rural living in their context was trying to obtain a high quality education for children.*** Two of the preceptors noted they had sent their children to private schools—at great financial and personal cost.

The ***benefits*** extolled by the preceptors about ***rural living*** included:

- low cost of living;
- respect in the community;
- quiet living;
- coming home at lunch time;
- excellent place to raise a family; and
- establishment of long term relationships with patients and families.

The preceptors noted several ***challenges*** related to ***rural practice***, including:

- lack of resources to conduct some diagnostic tests/procedures which results in referring the patient to an urban community, thereby inconveniencing the patient and family and delaying diagnosis and treatment;
- increased workload associated with a greater number of patients with chronic complex medical conditions,
- isolation from peers, and
- heavy on-call responsibilities.

The ***benefits of rural practice*** extolled by the physicians included:

- exposure to a variety of clinical situations which tests the physician's judgement and increases his/her confidence;
- developing a team-oriented approach to practice by working with other health care professionals;
- the ability to provide continuity of care because often the physician is serving several generations of the same family.

Because one goal of the 'shadowing program' is to generate future and continued interest in rural medicine, we asked the six medical students about their current level of interest in pursuing a career as a rural-based physician. Four of the six students (67%) stated they were 'somewhat interested', while two individuals (33%) reported they were 'very interested' in pursuing a career in rural medicine. While these individuals may, in the future, choose not to practice rural medicine, currently they have an expressed interest in becoming a rural-based physician.

Each of the six students reported that the shadowing experience had increased their level of interest in practicing as a rural physician and they provided the following comments:

- my interest in rural medicine increased after I saw how much the preceptor enjoys his work;
- my level of interest was increased somewhat because of the setup of the group practice; and
- the shadowing experience helped to clarify the size of rural community in which I might want to practice.

The data indicate that the preceptors seemed to have provided the students with a significant experience. However, two of the six medical students reported there was insufficient time to discuss their expectations respecting the shadowing experience and how the shadowing would unfold (i.e., the things they would be doing with the preceptor during the weekend).

Four of the six students (67%) stated they were 'somewhat satisfied' with the shadowing initiative, while two individuals (33%) reported they were 'very satisfied' with the experience. The best aspects of the shadowing initiative reported by the students include:

- doing procedures and exposure to clinical work;
- RPAP paid for the cost of travel to the site; and
- having the experience of being a rural physician for a weekend.

These students provided the following recommendations for improving the RPAP shadowing program:

- update the web site more often;
- better communication with the RPAP Medical Students' Initiative Coordinator—once this improved, the process of arranging for the experience also improved; and
- allow students to shadow more than once if there are available spaces in the program.

The Rural Tours and Shadowing Program is aimed at 'nurturing' medical students to choose rural medicine as a career by exposing them to rural practice in their early medical school education. At present, the RPAP Coordinating Committee does not view this initiative as a 'screening tool' to identify individuals who have 'rural potential' and, who could then be followed and supported through medical school.

B. Summer Student Experience Program

Description of the Summer Student Experience Program

The purpose of the Summer Student Experience Program is to encourage Regional Health Authorities to hire a medical student during their summer. This RPAP initiative started in 2003 and is intended to directly address the Vision and Mission of the RPAP by:

- exposing medical students early in their education to rural practice as part of their training;
- developing a level of sensitivity to the challenges of rural practice; and
- acculturating students to a rural lifestyle—(i.e., acculturation is a process of intercultural borrowing between diverse peoples resulting in a new and blended pattern).

The program provides a maximum of six grants annually. The grants range from a minimum of \$1,000.00 to a maximum of \$3,000.00 per medical student who has completed his/her first, second or third year, and who has obtained the agreement and support of a Regional Health Authority to sponsor a summer experience of 4 - 12 weeks duration. Generally, the summer experience should offer at least 2 days per week of clinical or community exposure to medical practice with the balance of the week geared to the completion of an RHA research ethics committee-approved or RHA/University research ethics committee-approved project with some patient exposure.

RPAP requires a report from each of the participants in the Summer Student Experience Program, which is to include:

- a description of the community and patient population serviced;
- a description of a typical day you experienced;
- presentation of any additional interesting experiences;
- the best things about the experience; and
- suggestions for improvement.

In an effort to encourage medical students to experience rural medicine in small communities, RPAP added four positions in April 2005 to its Summer Student Experience Program and preference on a first come, first served basis will be given to elective locations outside of the regional centres of Lethbridge, Medicine Hat, Grande Prairie, and Red Deer.

Effectiveness of the Summer Student Experience Program

To examine the effectiveness of this RPAP initiative, RPM personnel reviewed the written reports of six students who had participated in the Summer Student Experience Program in 2003 and 2004. We examined these reports in relation to the objectives of the initiative and to determine the value of the program to the student and to the RHA.

Four of the six medical students had placements in a regional centre, while two of the individuals worked with preceptors in medium sized rural communities ($\pm 6,200$ population). Accordingly, they did not have the opportunity to develop a level of sensitivity to the challenges of 'small town rural practice'.

Exposing students to rural practice

Our review of the reports submitted by the program participants indicate that students were exposed to rural practice. This occurred in a variety of ways, including:

- working closely with physicians who provide obstetrical services;
- being on-call and working in the Emergency Department of a rural hospital;
- observing a rural GP surgeon completing a carpal tunnel repair, and a breast tumour removal;
- assisting, in a limited capacity, with a number of surgeries—laparoscopic cholecystectomies, tubal ligations, and tonsillectomies; and
- performing, under supervision, some minor procedures such as gastroscopes and lump removals.

The reports indicated that students were exposed to a variety of patient populations. For example, in the same day it was easy for one student to see a farmer with equipment related injuries and a city accountant with a gall bladder disease. Another student was exposed to a large number of teen patients through a Teen Clinic, and a Spanish-speaking immigrant population since the preceptor is fluent in Spanish (Red Deer). These experiences are valuable because they demonstrate how important it is that physicians have the capability of being able to make people from all walks of life and cultures feel comfortable. Even in small rural communities such as Raymond, Bassano and Beaverlodge there are 'visible minorities'—including Chinese, Filipino, and Latin Americans.

Developing a level of sensitivity to the challenges of rural practice

From the information presented in the students' written reports, it appears that students did develop a level of sensitivity to the challenges of rural medicine through their exposure to the differences between urban and rural based practices.

For example, one student learned that the Emergency Department in rural communities often function as the 'after hours clinic'. The student commented that this created a different dynamic for rural physicians working in Emergency in contrast to an urban setting.

Another student was exposed to diverse patient populations which had a wide variety of health and sociocultural issues—and she thought this diversity would not be seen in many urban-based practices. Specifically, she worked with a physician who practices obstetrics and the student was exposed to the following patient populations:

- a number of prenatal referrals;
- teen patients seen at a Teen Clinic; and
- a Spanish-speaking immigrant population.

Acculturating students to a rural lifestyle

None of the reports submitted by the students addressed the issue of whether they were being acculturated to the rural lifestyle.

Value to the student

Based on the information presented in the students written reports, the Summer Experience Program has been valuable to the students in several ways.

It gave one student hands on experience (in Medicine Hat) in her Obstetrics and Gynaecology elective. This program provided valuable experiences in dealing with Women's Health issues and, through the clinical exposure, heightened the excitement of this student to Women's Health.

Another student noted that she 'wanted to gain a better understanding of what it is like to practice medicine in a rural setting'. During the summer she was able to work with primary care physicians and specialists. Prior to this experience she believed that 'patient care' in a rural setting would be compromised due to reduced accessibility to services. However, she discovered that the quality of medical care that rural patients receive 'may even exceed that received by patients in urban centres'. She also reported that the rural physicians seem to have more time for their patients than their urban counterparts, and the impact that this has on the doctor/patient relationship was evident. Accordingly, the summer experience for this student helped to dispel many myths she had regarding rural medicine.

Another student commented that the physician provided her with 'patient communication tips'. Specifically, she learned how to make each patient feel they were understood, cared for, and valued.

Value to the RPAP

In addition to providing value to the students, the Summer Student Experience Program may also provide some value to the Alberta Rural Physician Action Plan because some of the participants in this initiative *may* choose to rural practice. For example, one student wrote "I hope that I have the opportunity to work in rural Alberta", and another student noted "the clinical experience I had has certainly maintained my interest in the practice of rural family medicine." The support of the preceptors and the frequent on-call experiences only added to the exposure and excitement of their summer experience.

However, one has to acknowledge that because the participants in the Summer Student Experience Program in 2003 and 2004 had placements in either a regional centre or a medium sized rural community ($\pm 6,200$ population), there is a significant probability that these individuals will choose to practice in a larger community rather than a small/remote location. But, this could change in the future because in an effort to encourage medical students to experience rural medicine in small communities, RPAP added four positions in April 2005 to its Summer Student Experience Program and preference on a first come, first served basis will be given to elective locations outside of the regional centres of Lethbridge, Medicine Hat, Grande Prairie, and Red Deer.

In the future it may be desirable to know if the Summer Student Experience Program impacts a participant's decision to choose rural practice. However, this may be an unrealistic expectation because there are many factors involved in the selection of a practice location and, it could be quite difficult to precisely determine how much influence this one RPAP initiative has in a medical student's decision to practice rural medicine. Nonetheless, in an effort to try to identify the influence of the Summer Student Experience Program, RPAP could track the practice location of the individuals who participate in this initiative and undertake a comparative analysis with a cohort of medical students who did not participate in this RPAP program.

C. Rural Rotations for Calgary/Edmonton-based medical students and residents

Description of the RPAP Rural Rotations Initiative

RPAP promotes the concept of medical students and residents taking part of their training in a rural or regional community. The objective is to encourage rural practice and to provide a positive exposure to rural medical practice and to rural community living while students are still in training, and before they have made decisions as to where to practice.

The financial costs of providing medical students with a rural experience are covered by the Rural Physician Action Plan. RPAP covers accommodation and travel costs. The RPAP also reimburses the registration fees for ATLS certification and ACLS recertification for Family Medicine residents who undertake a rural rotation during their second year.

The preceptors in each of the training sites have a direct link to the university they are affiliated with and are supported through RPAP-funded faculty development and on-site visits. RPAP also provides an honorarium for the preceptors.

University of Alberta

The University of Alberta undergraduate medical program is four years, and students are off during the summer months. At the University of Alberta, medical students do a mandatory four-week rural rotation in their 3rd year, and they can also do electives in rural communities. These electives can take place for a duration of one to six weeks. Fourth year medical students can also do electives in rural communities.

Residents in the traditional Family Medicine Residency Program are required to do an eight-week rural rotation during the second year of the program.

University of Calgary

The University of Calgary undergraduate medical program is three years, and students are not off during the summer. At the University of Calgary, second year students select a Family Medicine site from a list of pre-arranged sites for their third year rural experience. This mandatory rural rotation is 4-weeks in duration.

At the University of Calgary, medical students can apply for an elective experience in a rural setting for up to four weeks between the first and second year of the undergraduate program. A further rural experience may be arranged by the student as an elective during the clerkship year (i.e., third year)—and this is not mandatory.

First year residents enrolled in the traditional Family Medicine Program at the University of Calgary may take core Family Medicine rotations in rural locations. Second year Family Medicine residents are required to spend at least two months of core Family Medicine experience in a rural community. Two additional months may be spent in a rural community.

Location of Rural Rotations

Because the objective of the rural rotations is to encourage rural practice and to provide a positive exposure to rural medical practice and to rural community living while students are still in training, it is important to verify that most undergraduate rural rotations actually take place in rural communities. Pong has written extensively about the fact that there is no common definition for what constitutes a 'rural community'. Nonetheless, most researchers define a community as rural if the population is less than 10,000 people.

For the purposes of this evaluation, we have examined data from both UofC and UofA respecting the location of the mandatory rural rotations for undergraduate medical students, and have classified rural rotation sites into the following sizes:

- <5,000 population;
- 5,000 - 10,000 population; and
- >10,000 population.

The data in Exhibits 8 and 9 show that between 1993 and 1997, more than 50% of the UofC clerks did their rotations in communities of <5,000 population. However, this decreased somewhat between 1998 and 2003—with the exception of 2001. During some of these years, there was a corresponding increase in the proportion of clerks undertaking their rotations in medium size rural communities (5,000 and 10,000 population) and in locations with a population exceeding 10,000 people. As of 2004, the percentage of clerks undertaking their rotations in small rural communities rose past 50%.

The data for UofA undergraduate medical students show a similar picture. Between 1994 and 1999, more than 50% of the UofA medical students did their rotations in communities of <5,000 population. However, this has decreased considerably since 2000, with a corresponding increase in the proportion of medical students choosing to undertake their 'rural rotations' in larger communities.

If rural rotations for undergraduate medical students are to act as an influencer in the career choice of these individuals, then it is important that most of these rotations take place in small to medium size communities. The data suggest that in the past few years medical students have been placed in larger communities for their rotations. Part of this perspective comes from classifying the communities with a reasonably large population spread—i.e., 5,000 - 10,000.

It is uncertain what the reasons are for this, although it may be due in part to the pressure to place a growing number of Family Medicine residents from the ARFMN in rural communities, thereby "squeezing out" clerks.

EXHIBIT 8

PERCENT OF UofC UNDERGRADUATE ROTATIONS IN DIFFERENT SIZE COMMUNITIES

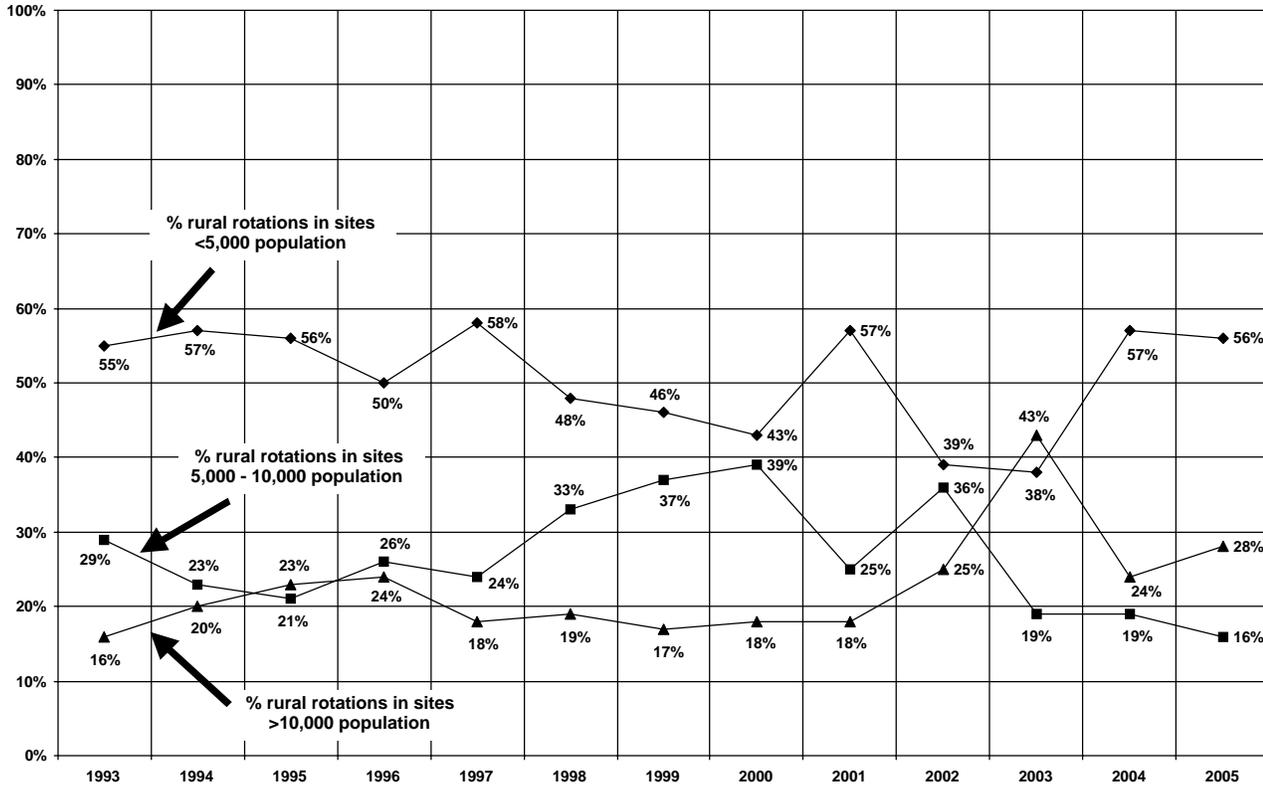
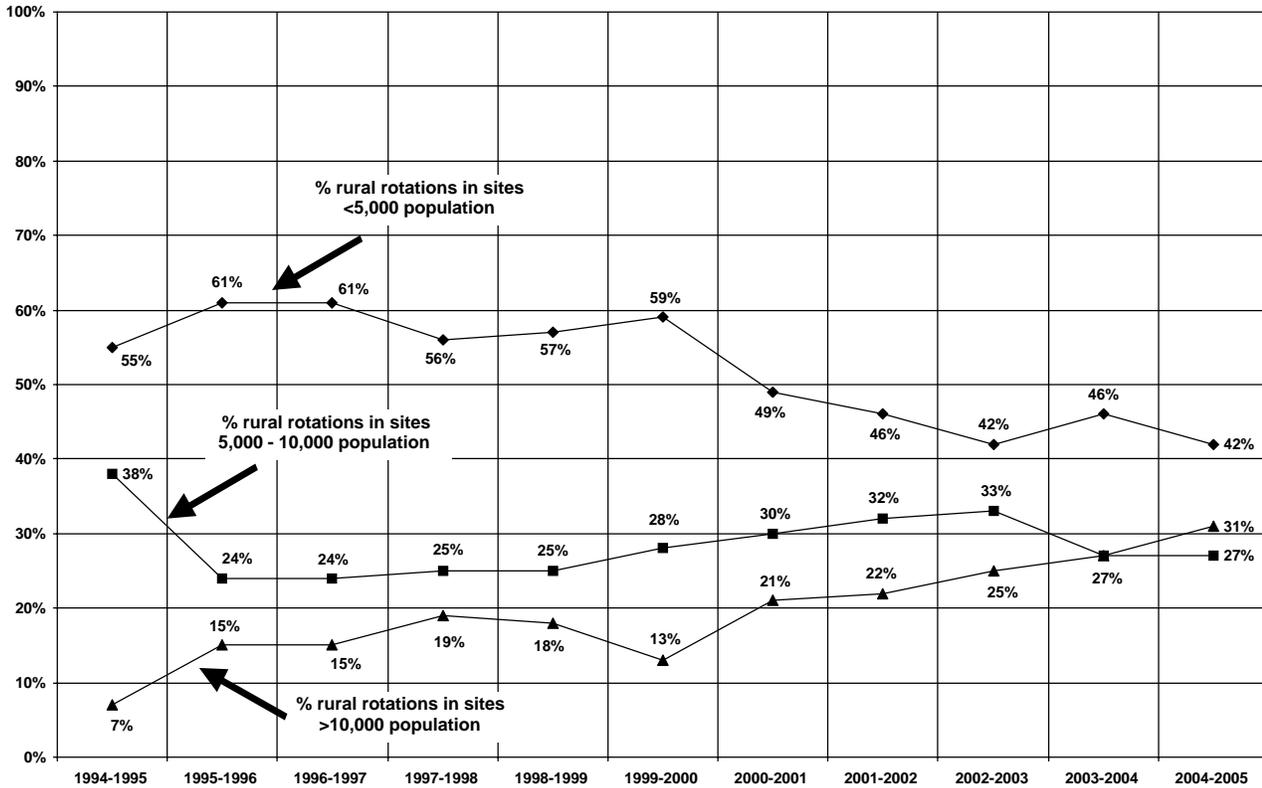


EXHIBIT 9

PERCENT OF UofA UNDERGRADUATE ROTATIONS IN DIFFERENT SIZE COMMUNITIES



Effectiveness of the Rural Rotations for Medical Students and Residents

To assess the effectiveness of the rural rotations for medical students and residents, RPM personnel conducted interviews with medical students from the University of Alberta who had participated in a rural rotation. For several years the University of Calgary Family Medicine Program has been conducting a comprehensive survey of the opinions of the medical students respecting their rural rotation undertaken during the clerkship year (i.e., 3rd year). Accordingly, we chose to use the results of these surveys rather than duplicating the work already completed by the University of Calgary Undergraduate Medical Education Office—under the RPAP.

RPM personnel also reviewed the medical students' and residents' evaluations of the rural rotation sites. In addition we interviewed rural preceptors who accept medical students and residents on rotation.

RPM also reviewed documents that report the degree to which RPAP has achieved its Key Performance Indicators respecting 'rural rotations'. These documents list the RPAP goal, and associated KPI and target, and a measurement of the extent to which the goal was achieved.

One of RPAP's 'rural rotation' goals is that all undergraduate medical students will have the opportunity to receive suitably supervised exposure to rural medical practice. While this is laudable, RPAP realizes that it may not be possible to achieve this goal. Accordingly, a more realistic target has been set by the RPAP Coordinating Committee. In the case of this particular goal, there is a 'target' of 75%. That is, there is an expectation that both universities should be able to ensure that 75% of undergraduate medical students at UofA/UofC receive a rural/regional rotation.

Our examination of the KPI data shows that the UofA has exceeded the target in each of the past five academic years (1999/2000 to 2003/04), and the UofC has surpassed the 75% target in each of the past four years. Accordingly, most medical students at the two universities have been exposed to rural medical practice through medical rotations, which, as noted earlier from our review of the literature, is a key element in influencing students to choose a career as a rural-based physician.

As noted in the literature, simply exposing medical students to rural practice does not necessarily ensure that the experience will increase their willingness to choose a career in rural medicine. There are some critical aspects of the rural experience that are important ingredients in facilitating the possibility that medical students and residents will choose a career in rural practice, such as:

- understanding rural culture, small community living;
- knowing how to balance work and personal life;
- being able to establish personal/professional boundaries;
- being able to take on the role of community leader; and
- feeling comfortable and confident with the clinical demands of rural practice.

Exhibit 10 presents data from students and preceptors respecting the rural rotation experience. We have used information from the 2002, 2003 and 2004 UofC Clerkship Surveys, as well as data from the UofC Rural Preceptor Surveys for 2002 and 2004. Exhibit 10 also contains information from the interviews RPM conducted with fifteen rural preceptors in 2005.

We did obtain the opinions of seven UofA medical students respecting their rural rotation experience, but the numbers are too small to use for comparative purposes and, therefore do not appear in Exhibit 10. To supplement our information for UofA medical students, RPM personnel reviewed 205 rural rotation site evaluation forms completed by these students between 2003 and 2005. Our analysis of the information is presented after Exhibit 10. We found that the UofA medical students had a rural rotation experience similar to the UofC clerks.

Both the UofC Clerkship Survey and the UofC Rural Preceptor Survey asks respondents to rate several elements as to whether they were a strong, neutral or weak feature of the rotation. Since the undergraduate rural rotation provides an important opportunity to influence student's career choice, we believe that at a minimum, 80% of students should be receiving a 'strong' experience in each of the 'clinical' and 'non-clinical' elements of medical practice.

Are the rural rotations providing medical students with the type of experience that will facilitate these individuals choosing to practice rural medicine? Using the information from Exhibit 10 and applying it to the critical ingredients noted in the literature, it seems as though medical students are exposed to the role of the family physician in the community, but less to the 'physician lifestyle' and 'different practice styles'. The data show that less than 80% of preceptors consider their rotations to adequately address these latter two elements. These data suggest some students are not being exposed to experiences which would help them learn about the challenges faced by rural physicians in balancing work and personal life, and the importance of establishing personal/professional boundaries. The lack of exposure to the physician lifestyle will also hinder the students' preparedness to assume the role of community leader.

Although 93% of the 15 rural preceptors interviewed by RPM personnel stated that 'continuity with the preceptor' and 'preceptor teaching/feedback' is a strength in their rotation sites, less than 70% of the preceptors surveyed by the UofC indicated that these two elements are a strength in their sites. These data suggest that a significant portion of medical students do not necessarily have the opportunity to engage the preceptor in thoughtful discussion related to important 'non-clinical' aspects of medical practice such as work/life balance issues, dealing with anonymity in the community, and how to adjust to a community's expectation about the role of the physician as a community leader.

Exhibit 10 indicates that the rural rotations allow most students to practice previously learned skills and call/emergency experience, thereby increasing their degree of comfort and confidence with their ability to handle some of the clinical demands of rural practice. However, students do not necessarily have the opportunity to learn new clinical skills or procedures, or be exposed to a substantial amount of hospital work. This lack of experience reduces the potential of the rural rotation to increase a student's degree of comfort and confidence with his/her ability to deal with the reality demands of rural practice.

EXHIBIT 10

STRENGTHS OF THE RURAL ROTATIONS AS RATED BY UofC CLERKSHIP STUDENTS AND RURAL PRECEPTORS

Rural Rotation Experiences	UofC Family Medicine Clerkship Survey 2002 to 2004 Rural Rotations Only (Mean/Yr. N = 57)	UofC Rural Preceptor Survey 2002 and 2004 (Mean/Yr. N = 23)	RPM Interviews With Rural Preceptors 2005 (N = 15)
Rural Practice/Lifestyle Aspects of the Rotation (5)			
Exposure to role of family physician in the community	91%	93%	100%
Exposure to variety of common problems	90%	89%	100%
Wide range of experiences	82%	91%	87%
Exposure to physician lifestyle	72%	73%	53%
Exposure to different practice styles	72%	76%	73%
Clinical Aspects of the Rotation (9)			
Opportunity to practice previously learned skills	90%	89%	87%
Call/emergency experience	81%	89%	80%
Hospital exposure	75%	82%	93%
Patient volume	74%	69%	93%
Opportunity to learn new clinical skills	74%	80%	80%
Opportunity to learn procedures	74%	78%	80%
Patient mix	72%	82%	93%
Responsibility for patient care	69%	91%	93%
Continuity with patients	58%	73%	80%
Interaction With the Preceptor (2)			
Continuity with preceptor	71%	69%	93%
Preceptor teaching/feedback	65%	69%	93%

As noted earlier, RPM personnel reviewed 205 rural rotation site evaluations completed by UofA medical students between 2003 and 2005 respecting their experience in 26 communities. Most of the UofA medical students considered the rotation to be 'excellent' and most recommended the site for consideration by other students. The following are examples of the strengths identified by students at different rotation sites, which is reasonably comparable to the data from the UofC clerks:

- good ER experience;
- good mix of inpatient, ER, and family clinic experience;
- extremely friendly people in the community;
- opportunities to perform procedures;
- opportunities to examine a variety of patients;
- independence to take a history/physical, diagnose and suggest a treatment plan; and
- opportunity to do half-days and full-days in different areas and specialties.

D. Physician Recruitment Fairs

Description of the Physician Recruitment Fairs

The Physician Recruitment Fairs provide an opportunity for medical students and residents to meet with RHAs, physicians and community representatives from around the province. This event gives medical students a chance to start building relationships for future rotations and practice after graduation. The Recruitment Fairs are held in September of each year.

Effectiveness of the Physician Recruitment Fairs

During the Recruitment Fairs, residents and medical students are provided with an evaluation form. To assess the effectiveness of the Physician Recruitment Fairs RPM personnel analyzed the data from these evaluation forms.

Approximately 95% of the residents and medical students complete the evaluation forms. About 98% of these individuals indicated the Recruitment Fair 'met their expectations'.

The data in Exhibit 11 show that more than half of the residents and slightly more than one-quarter of the medical students attended the Recruitment Fair 'looking for a rural practice opportunity'. At the time of the Recruitment Fair a large proportion of both groups were 'undecided about a rural practice opportunity'. Nonetheless, about three-quarters of the residents and medical students indicated they were planning to follow-up with rural/regional RHAs, communities, or the Rural Locum Program.

The evaluation form includes a list of factors which would encourage the residents/medical students to practice in a rural community. It is interesting to note from Exhibit 11 that 'proximity to an urban area or metro centre' was one of the most frequently cited considerations or factors that would encourage them to practice in a rural community. This could be a potential barrier for recruiting physicians to small and remote rural communities.

The 'spousal' factor is also quite predominant. This is consistent with findings from several researchers as reported in the literature.

EXHIBIT 11

**RESIDENTS AND MEDICAL STUDENTS OPINIONS OBTAINED DURING THE
RECRUITMENT FAIRS IN CALGARY AND EDMONTON 2002 TO 2004**

Items From the Recruitment Fair Evaluation Forms	No. of Residents (N = 98)	No. of Medical Students (N = 257)
Looking for a rural practice opportunity	57%	27%
Not looking for a rural practice opportunity	4%	10%
Undecided about a rural practice opportunity	39%	63%
Total	100%	100%
Follow-up After The Recruitment Fair	No. of Residents (N = 97)	No. of Medical Students (N = 110)
Planning to follow-up with RHAs, communities or the Rural Locum Program	78%	71%
Expect the RHAs, etc. to follow-up with them	22%	14%
Undecided	0%	15%
Total	100%	100%
Factors that would encourage them to practice in a rural community	No. of Responses From Residents (N = 154)	No. of Responses From Medical Students (N = 389)
The number of physicians already in practice	20%	15%
The proximity to an urban area or metro centre	19%	20%
Ability to obtain locum coverage	14%	13%
Opportunity for continuing medical education	14%	11%
Employment opportunities for my spouse	14%	15%
Location of relatives	8%	12%
Where spouse wants to live	12%	13%
Total	100%	100%

E. Matching Signing Bonus

Description of the Matching Signing Bonus

The matching signing bonus for rural practice program is a joint effort between the RPAP and participating Regional Health Authorities (RHAs). New Alberta-trained physicians (medical school and/or residency training) are eligible for a matching bonus to a maximum of \$10,000 from the RPAP for signing a Return-in-Service Agreement (RiSA) with a participating RHA for practice in a rural or regional community. The terms of the RiSA must be for a minimum of one year.

The physician must begin practice within 12 months of completing his/her residency. The number of matching signing bonuses for practice available from the RPAP may vary on an annual basis. They are provided on a "first come" basis. A physician may only receive the matching RPAP signing bonus for practice once.

Effectiveness of the Matching Signing Bonus

To assess the effectiveness of the 'Matching Signing Bonus', RPM personnel examined statistics related to the utilization of this initiative and interviewed six of the physicians who participated in this RPAP program in 2003/04 and 2004/05. In these two years, 16 physicians received a Matching Signing Bonus.

The data presented in Exhibit 12 show that the Matching Signing Bonus has not attracted individuals to practice in small communities. For example, half of the recipients are practicing in large rural/regional centres such as Camrose, Red Deer, or Medicine Hat (>10,000 population). Moreover, another 38% are practicing in small/medium size rural communities such as Peace River (±6,200 population), Olds (±6,600 population), Sylvan Lake (±7,500 population), and Hinton (±9,400 population). Exhibit 12 also indicates that one individual is no longer in Alberta and another is not in rural practice.

EXHIBIT 12

LOCATION OF PHYSICIANS WHO RECEIVED A MATCHING SIGNING BONUS

Year	2003/04	2004/05	Total	Percent
Practicing in Large Rural/Regional Centres (>10,000 population)	6	2	8	50%
Practicing in a Small/Medium Size Rural Communities (5,000 - 10,000 population)	2	4	6	38%
No Longer Practicing in a Rural Community	1	0	1	6%
No Longer Practicing in Alberta	1	0	1	6%
Total Receiving A Signing Bonus	10	6	16	100%

During our interviews with six of the 16 recipients of the Matching Signing Bonus, most reported they were motivated to apply for the financial assistance to help them in either paying down their student debt or putting a down payment on a home. All six physicians indicated it was very easy to apply for the money because the Regional Health Authority took responsibility for completing the paper-work and the physician only had to sign the completed application form and the Return-in-Service Agreement.

Half of the six recipients we interviewed signed a two-year RiSA, while the other 3 physicians signed a three-year RiSA. Five of the six physicians reported they intend to stay in their current community at the end of the term of the RiSA. The one individual who will likely be leaving will be moving to a large rural community (>10,000 population) because of educational opportunities for the family.

The six recipients of the Matching Signing Bonus benefited in different ways. For example, one physician stated, "although the amount of money is quite small compared to what is offered in the U.S., it made me feel wanted." Another individual reported, "it gave me money at a time when I was broke, and it was an added attraction to practice in a rural community." One other person stated, "the Signing Bonus was only of marginal benefit because I was already carrying a lot of debt."

Sempowski (2004)¹⁷ found that there has been very little research regarding the effectiveness of return-of-service commitments (ROs). All of the ROS programs reviewed by Sempowski achieved the goal of short-term recruitment. He points out that “the goal of long-term retention in rural or underserved areas is less well established.”

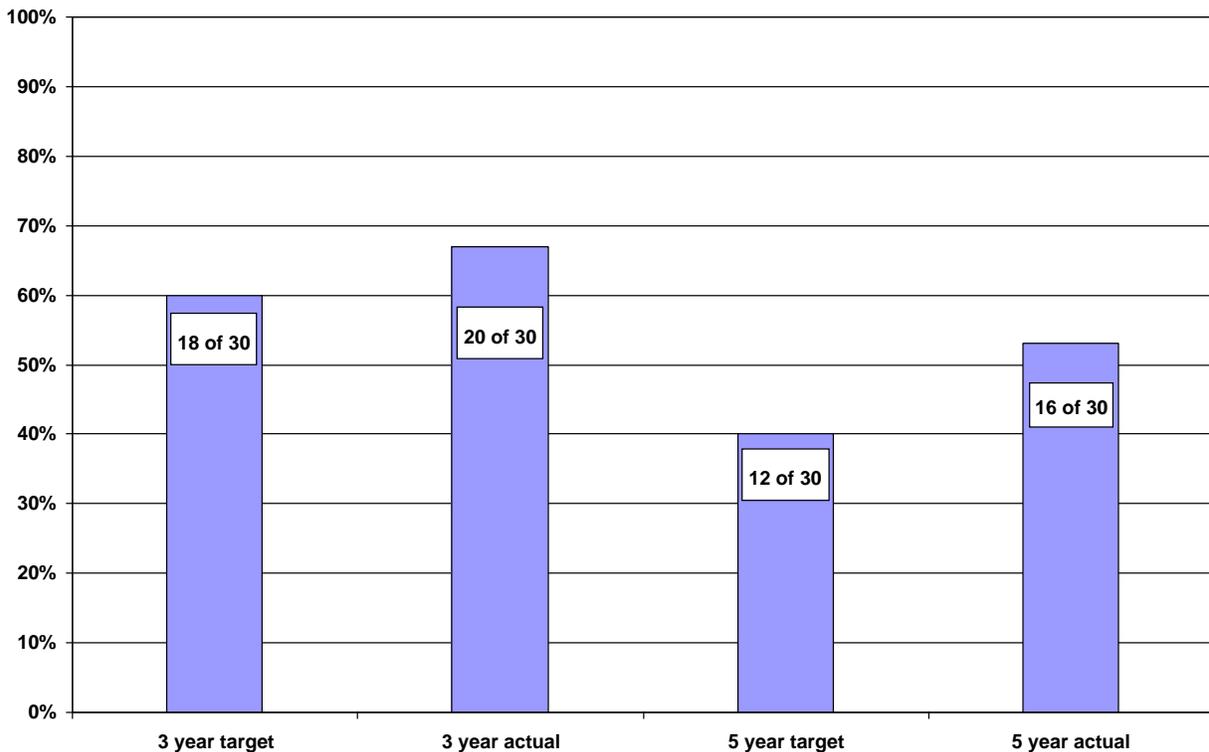
How effective has RPAP’s Matching Signing Bonus been in achieving its ‘retention targets’? Data from the Key Performance Indicator Report prepared by RPAP in relation to the 2003/04 Annual Report shows that the Matching Signing Bonus has exceeded the targets of 60% retention after three years and 40% after five years (see Exhibit 13).

Between 1997/98 and 1999/2000, 30 individuals had received a Matching Signing Bonus and 20 of these physicians (67%) stayed in their ‘original’ community for 3 years. Only 5 of these 20 physicians practiced in a small rural community (<5,000 population), 7 practiced in medium sized communities (5,000 - 10,000 population), while 8 stayed in large communities (>10,000 population), such as Camrose, Canmore, Grande Prairie and Fort McMurray.

Exhibit 13 also shows that 16 of the 30 physicians (53%) stayed in their ‘original’ community for 5 years.

EXHIBIT 13

MATCHING SIGNING BONUS RETENTION RATES



17. Sempowski, I.P, Effectiveness of financial incentives in exchange for rural and underserved area return-of-service commitments: systematic review of the literature. Canadian Journal of Rural Medicine 2004: 9 (2) 82-88.

3.2.2 Conclusions: RPAP's Student Education Initiatives

There are eight key conclusions we can draw from our findings in this section:

1. The Skills Days, hospital tours and shadowing initiatives are effective in exposing medical students to rural practice. These initiatives help students to build on and integrate their work in the classroom.
2. The Summer Student Experience Program is achieving its objectives of: (1) exposing students to rural practice as part of their training; and (2) developing a level of sensitivity to the challenges of rural practice. **It was not clear from the collected data as to whether this initiative is achieving its third objective—of acculturating students to a rural lifestyle.**
3. The rural rotations provide an important opportunity to influence the career choice of medical students and residents. Most medical students and residents receive significant value during their rural rotation—particularly related to honing their previously learned clinical skills. However, medical students unlike residents do not necessarily have the opportunity to learn new clinical skills or procedures, or be exposed to a substantial amount of hospital work. This lack of exposure may be related to the level of training clerks possess. However, it may reduce the potential of the rural rotation to increase a medical student's degree of comfort and confidence with his/her ability to deal with the reality demands of rural practice.
4. The rural rotations are somewhat less concerned with 'non-clinical' aspects of medical education for undergraduates. Perhaps preceptors perceive that students will absorb the 'non-clinical' aspects of medical practice by following the preceptor around and briefly talking about the rural physician lifestyle in between clinical discussions. However, a significant proportion of the preceptors noted that 'continuity with the preceptor' and 'preceptor teaching/feedback' is not a strength at their site. Accordingly, some specific activity needs to be directed to these 'non-clinical' domains of the rural rotation in order to achieve some of the objectives stated in RPAP's 2005-2008 Business Plan—i.e., (1) developing a level of sensitivity to the challenges of rural practice; and (2) acculturating students to a rural lifestyle.
5. The Recruitment Fairs do provide an opportunity for medical students and residents to meet with RHAs, physicians and community representatives from around the province. And, both medical students/residents have a chance to start building relationships for future rotations and practice after graduation. However, a significant proportion of residents attend the Recruitment Fairs even though they are not necessarily looking for a rural practice opportunity at that time.
6. 'Proximity to an urban area or metro centre' is considered by both residents and medical students to be an important consideration which would encourage them to practice in a rural community. This could be a potential barrier for recruiting physicians to small and remote rural communities.
7. Although the annual utilization of the Matching Signing Bonus Initiative is small, it is of value to many of the recipients. The fact that the Matching Signing Bonus has exceeded the targets of 60% retention after three years and 40% after five years indicates that the Return-in-Service-Agreement helps to keep physicians long enough that a significant percentage establish roots in the community.
8. The Matching Signing Bonus Initiative may assist some RHAs to recruit new Alberta-trained physicians to rural communities. However, the evidence suggests this RPAP initiative has not helped to recruit physicians to small/remote locations.

3.2.3 Recommendations: RPAP's Student Education Initiatives

RECOMMENDATION #1:

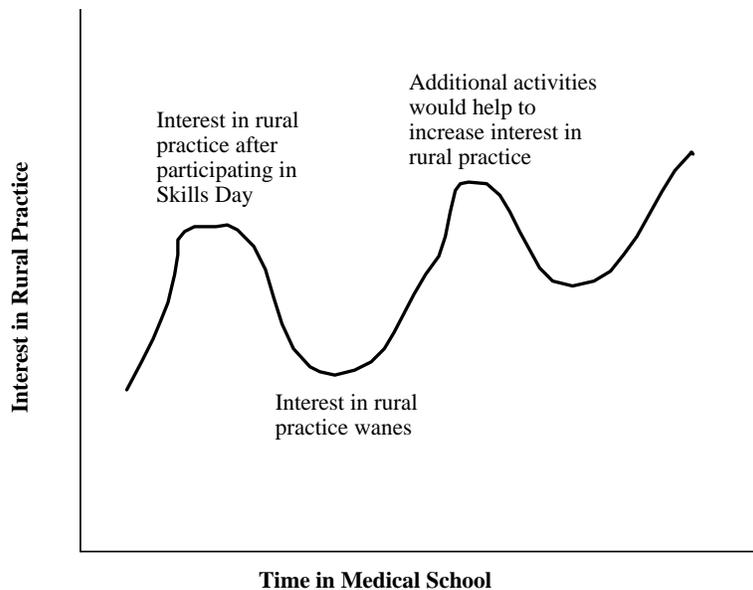
It is recommended that RPAP increase the number of Skills Days and shadowing opportunities in order that a student can participate in more than one opportunity per year, thereby keeping their interest in rural medicine high.

Explanatory Note:

The medical students who participated in our focus groups and interviews emphasized that the Skills Days and the shadowing opportunities excite them about rural practice. They noted, however, that over time their interest wanes and it would be helpful if students had more opportunities to participate with rural physicians as a way of keeping their interest in rural practice at its peak (as per Exhibit 14). Partly in response to this feedback, the RPAP now schedules shadowing experiences year round rather than during October to May.

The RPAP CC will have to decide how to increase the number of Skills Days and shadowing opportunities without burdening the current complement of rural preceptors.

EXHIBIT 14



RECOMMENDATION #2:

It is recommended that RPAP increase its effectiveness in communicating with medical students respecting arrangements for Skills Days, hospital tours and shadowing opportunities.

Explanatory Note:

During our focus groups with medical students they pointed out there had been some delay in learning about the availability of shadowing opportunities and in making final arrangements through the RPAP staff. This created significant frustration for the medical students and impacted their confidence in RPAP's ability to successfully complete the arrangements for various shadowing opportunities.

In part this occurred during the transition between consultants acting as the Medical Students' Initiatives Coordinator in the summer of 2004 and in the relative effectiveness of the RPAP-sponsored RMIGs acting as conduits between the RPAP and interested medical students.

The Medical Students' Initiatives Coordinator has taken the lead to improve communication with the RMIGs, to assist the RMIG executives plan an entire year of activities early after their election in August-September, and to use the new RMIG web sites to communicate the availability of shadowing experiences.

The RPAP Program Manager should request a quarterly report from the Rural Medicine Interest Groups. This would alert the Program Manager to emergent issues.

RECOMMENDATION #3:

It is recommended that RPAP develop more specific expectations for the reports submitted by individuals who participate in the Summer Student Experience Program to ensure their experiences are achieving RPAP's stated objectives for this initiative.

Explanatory Note:

Currently the RPAP Program Manager sends a letter to the successful Summer Student Experience Program applicants. The letter outlines "some of the main points that RPAP would like the student to incorporate in his/her report." However, since the program is intended to facilitate the achievement of the following RPAP objectives, RPAP should request a report which, at a minimum, addresses the extent to which the experience:

- exposed students to rural practice as part of their training;
- developed a level of sensitivity to the challenges of rural practice; and
- acculturated students to a rural lifestyle.

By establishing standardized requirements for the reports, RPAP will be able to systematically assess the extent to which its objectives for the Student Summer Experience Program are being achieved.

RECOMMENDATION #4:

It is recommended that RPAP and the two universities work together to ensure most of the rural rotation preceptors dedicate sufficient time to discussing non-clinical issues of rural medicine with students and residents.

Explanatory Note:

Particular attention should be paid to exposing students and residents to the challenges faced by rural physicians in balancing work and personal life, and the importance of establishing personal/professional boundaries. There should also be a focus on preparing students/residents to assume the role of community leader. This will require establishing explicit expectations for preceptors, encompassing both clinical and non-clinical aspects of the rotation.

It is recognized that the relationship between RPAP and the two universities has continued to evolve over time. The role of the universities in training students for rural practice has also evolved. This growth and change will help facilitate discussions to find ways to equip students with the skills they require to handle the challenges of rural practice.

Implementation of this recommendation may best be achieved by working through the new RPAP Rural Academic Development Officer.

RECOMMENDATION #5:

It is recommended that RPAP and the two universities work together to ensure that a majority of students/residents participate in a rotation in a small/remote rural community.

Explanatory Note:

If rural rotations for undergraduate medical students are to act as an influencer in the career choice of these individuals, then it is important that most of these rotations take place in small to medium size communities. The data suggest that in the past few years medical students have been selecting larger communities for their rotations. Part of this perspective comes from classifying the communities with a reasonably large population spread—i.e., 5,000 - 10,000.

However, it is acknowledged that with 240 clinical clerks to place annually, together with 44 ARFMN residents and nearly 100 traditional Family Medicine residents and dozens of Royal College residents, finding sufficient numbers of suitable rural teaching sites is a challenge.

3.3 RPAP'S PRACTICING PHYSICIAN SUPPORT INITIATIVES

This section presents our findings and conclusions respecting the following RPAP 'physician support' initiatives:

- Medical Information Service/Virtual Library
- Royal College re-entry positions
- Rural physician retention/innovation grant program
- Award of Distinction program
- Enrichment program
- Faculty Development

To assess these initiatives RPM collected information through a survey of rural physicians that was distributed by RPAP with directions to mail/fax the completed questionnaire to RPM to ensure the confidentiality of the information. We received 79 completed questionnaires.

3.3.1 Findings: RPAP's Practicing Physician Support Initiatives

A. Medical Information Service/Virtual Library

Description of the Medical Information Service/Virtual Library

The Medical Information Service is provided for the RPAP through the University of Calgary. This service helps rural physicians obtain rapid access to up-to-date medical information. The companion Virtual Library provides free access to subscription-based Internet-based medical textbooks, journals and other resources for rural physicians.

For example, rural physicians can access the following information through the Virtual Library:

- Canadian Compendium of Pharmaceuticals & Specialties
- MD Consult
- Clinical Practice Guidelines
- Harrison's On-line Textbook of Internal Medicine—updated weekly
- ACP Medicine Textbook of Internal Medicine—updated monthly
- ACS Surgery Textbook of Surgery—updated monthly
- OSLER (Canadian Medical Association)
- Canadian Library of Family Medicine
- PubMed (US National Library of Medicine)
- MEDLINE medical literature database

Effectiveness of the Medical Information Service/Virtual Library

To assess the Medical Information Service (MIS)/Virtual Library, RPM personnel used the information obtained from a survey completed by 79 rural physicians. The data show that 54% of the surveyed physicians have heard about the Medical Information Service. Exhibit 15 illustrates that 37% of those physicians who have heard about the MIS have used it.

Eighty percent of the responding physicians reported having heard about the Virtual Library (63 of 79) and slightly more than half of these individuals use the Virtual Library.

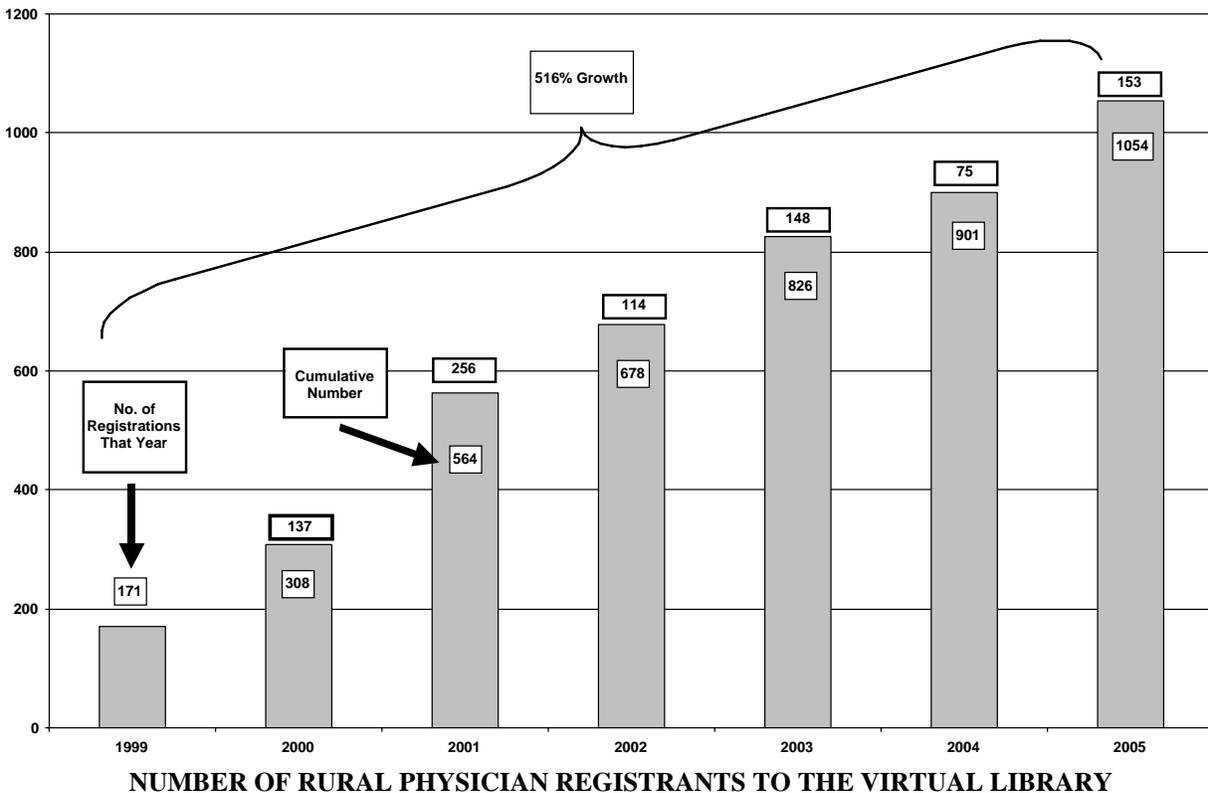
EXHIBIT 15

PERCENT OF USERS OF THE MIS AND VIRTUAL LIBRARY

Rural Physicians Who Have Heard About These Initiatives	Heard About/Use	Heard About/Don't Use
Medical Information Service (N = 43 of 79)	16 (37%)	27 (63%)
Virtual Library (N = 63 of 79)	33 (52%)	30 (48%)

The data in Exhibit 16 illustrates there has been an increasing number of rural physicians registered with the Virtual Library. The 1,054 current registrants represent almost 75% of all rural physicians. The Virtual Library is managed by the Director, Medical Information Service, University of Calgary. During our interview, he stated that the data reflects only physicians currently working in rural communities. He pointed out that he identifies “dropouts” by comparing the current user list to the quarterly membership list received from the College of Physicians and Surgeons.

EXHIBIT 16



Surveys conducted by the UofC of registered users of the Virtual Library in 2002/03 and 2003/04 show that most respondents are either 'satisfied' or 'very satisfied', with a mean of 4.3/4.4 respectively out of 5 (where '5' is 'very satisfied'). Based on this information, it is not surprising that users of the MIS/Virtual Library who responded to our Physician Survey for the evaluation reported the following benefits of this service:

- access to a university resource from a rural area;
- easy access to high quality medical reference and other relevant information;
- access to tests and journals (MD Consult);
- point of care information;
- use it for detailed information and depth, CD products and ASA remedies; and
- able to search clinical questions.

B. Royal College Re-entry Positions Initiative

Description of the Royal College Re-entry Positions Initiative

Under the auspices of RPAP, rural physicians have the opportunity to return for training in a Royal College specialty program. To apply for a Royal College re-entry position, physicians must contact the Associate Dean of Postgraduate Medical Education at either UofC or UofA.

The number of positions available varies from year to year. For example, one position was available for July 2004 and one for July 2005. The number of positions available is not known until after the CaRMS match.

Effectiveness of the Royal College Re-entry Positions Initiative

Thirty-six of the 79 rural physicians, who responded to our Physician Survey for the evaluation, had heard of the Royal College re-entry initiative (46%). Of these 36 physicians, 11 have actually used the program (31%—11 of 36). Eight of these 11 physicians noted RPAP should endeavour to increase the number of Royal College Re-entry positions.

C. Rural Physician Innovation/Retention Grant Program

Description of the Rural Physician Innovation/Retention Grant Program

The purposes of the Rural Physician Innovation/Retention Grants Program are to foster the development of:

- innovative program ideas for the benefit of rural physicians; or
- project ideas for physician retention targeted at the local level.

The grants are intended to provide one-time funding for a short-term project or seed funding for a long-term project. Physicians who submit an application must explain the innovation or retention proposal and how the proposed project is innovative or differs from existing initiatives.

The following are some examples of initiatives funded through the Innovation/Retention Grants Program:

- a FP-Anaesthesia Simulator Maintenance of Competence Proposal;
- a Zyban research project; and
- ICPC Pocket and Pocket Prof projects.

Effectiveness of the Rural Physician Innovation/Retention Grant Program

Thirty-five of the 79 rural physicians, who responded to our Physician Survey for the evaluation, had heard of the Rural Physician Innovation/Retention Grants Program (44%). Of these 35 physicians, only 5 have actually used the program.

In 2001/02 and 2002/03 the RPAP Coordinating Committee had allocated \$200,000 to the Rural Physician Innovation/Retention Grants Program. However, this was reduced to \$100,000 for 2003/04 because of the lack of proposals in previous years from the rural physician community.

The Rural Physician Innovation/Retention Grants Program is listed in each of the Annual Reports as an RPAP initiative. However, no information is published in these documents about any of the specific projects that were funded. Providing examples, in future Annual Reports, of projects that have been funded under this program, may inspire others to submit proposals.

D. Award of Distinction

Description of the Award of Distinction Program

The Rural Award of Distinction was created in 2002 to recognize the contributions of all rural physicians, especially those 'unsung heroes' who provide Alberta rural communities with outstanding medical services and who also make significant contributions to medical practice and to their communities. Each year for the Award community event, the RPAP produces a tribute video related to the medical and other contributions of the Award recipient.

People who want to nominate a physician for an Award of Distinction must write a letter to RPAP that gives an overview of the nature and scope of the nominee's achievements including:

- how his/her superior contribution and commitments have made a difference to the community through medical practice, teaching, research and/or community service;
- his/her personal characteristics that made the achievements possible; and
- the obstacles the physician had to overcome to achieve the contributions.

The RPAP Communications Consultant is responsible for all of the communication and marketing/promotion of the Award of Distinction Program. This involves working extensively with television and print media. Some of the other responsibilities of the RPAP Communications Consultant related to the Award of Distinction Program include working with the 'recipient' community to organize the award night, and arranging for the 'video shoot'.

Effectiveness of the Award of Distinction Program

Thirty-nine of the 79 rural physicians, who responded to our Physician Survey for the evaluation, had heard of the Award of Distinction Program (49%). Of these 39 physicians, only 5 have actually participated in the program by nominating a colleague for an Award of Distinction.

Some of the RPAP CC members and external RPAP stakeholders have commented that the Award of Distinction Program is an important way of highlighting the significant contributions of rural physicians.

E. Enrichment Program

Description of the Enrichment Program

The Enrichment Program enables practicing physicians in rural Alberta to upgrade or to gain new skills in order to meet the medical needs of the community or surrounding areas. There are a variety of different skills the Enrichment physicians have acquired, including obstetrical, psychiatric, diagnostic imaging and emergency medicine skills.

The length of training required will vary depending on the physician's background and the agreed learning objectives. In order to qualify for the Enrichment Program, the training period can be no less than two (2) weeks and not greater than twelve (12) months. Physicians accepted in the Enrichment Program receive an honorarium of \$76,000 per year, prorated for the length of training. Preceptors are eligible for an honorarium of \$1,000 per month, prorated for the length of the training.

The preceptor will:

- establish learning objectives with the trainee;
- provide the required training within the agreed learning objectives; and
- ensure that an evaluation of the trainee occurs at the end of training

Effectiveness of the Enrichment Program

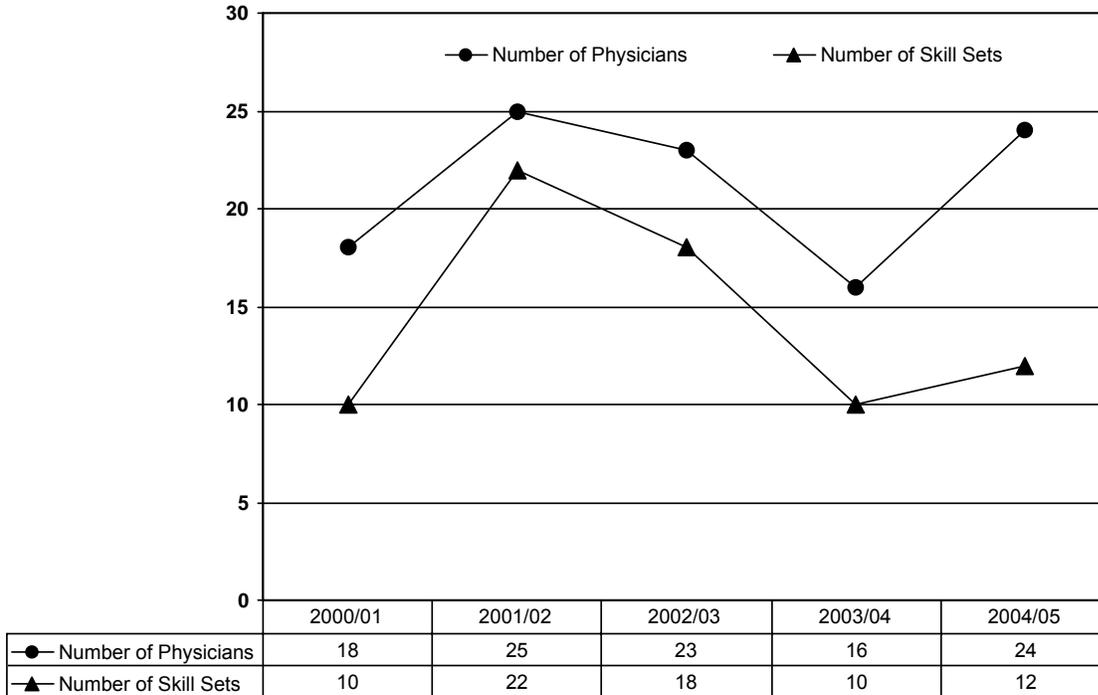
More than 100 physicians have participated in the Enrichment Program since its inception in 2000/01(see Exhibit 17). There are a variety of different skills the Enrichment physicians have acquired including obstetrical, psychiatric, diagnostic imaging and emergency medicine skills. These physicians are better equipped to meet the health needs of their communities.

The evaluation of the Enrichment Program conducted in 2000¹⁸ indicated that the enrichment training does facilitate the acquisition of additional competencies and upgrading existing skills, which helps a physician feel more confident and comfortable in performing specific procedures. The evaluation found that "acquisition of additional competencies makes the physician more marketable, and also increases the financial benefits to the physician since he/she can bill the Alberta Health Care Insurance Plan for more procedures. These factors help retain the physician in the community."

18. RPM Planning Associates Limited, Evaluation of the RPAP Additional Skills Training Program and Enrichment Program. 2000.

EXHIBIT 17

NUMBER OF PHYSICIANS AND SKILLS SETS ACQUIRED



THROUGH THE ENRICHMENT PROGRAM

F. Faculty Development Initiatives

Description of Faculty Development Initiatives

The RPAP implemented the Alberta Rural Family Medicine Network (ARFMN) starting in 2000-2001 as part of the previous three-year business plan. In addition, with RPAP funding and support, both the University of Calgary and the University of Alberta encourage medical students and residents (Family Medicine and Royal College) to do mandatory and elective rotations with rural and regional preceptors.

The two universities have been working to support the goals and objectives of these initiatives by designing and implementing ‘faculty development’ programs for rural and regional preceptors to strengthen their teaching skills. The UofC and UofA collaborate in planning and delivering two major (big box) faculty development events annually—one in Southern Alberta, usually held at Kananaskis (called Cabin Fever), and the other in Northern Alberta, held in Edmonton (called Spring Seeding). In addition, both universities deliver ‘faculty development’ workshops in local and regional sites throughout the year.

Effectiveness of Faculty Development

RPM interviewed preceptors as part of its evaluation of the ARFMN, conducted in 2003/2004. These preceptors reported that the “big box” faculty development workshops are effective. Some of the physicians we interviewed stated they learned the following things at Cabin Fever or Spring Seeding which assists them as a preceptor for the ARFMN:

- ideas of presenting feedback to residents;
- opportunity to discuss preceptor issues with colleagues; and
- learning how to teach practical skills to residents.

As part of the evaluation of the Alberta Rural Physician Action Plan, RPM personnel attended the faculty development workshop in Kananaskis held in February 2005. We attended several of the workshops and observed that some of these sessions provided preceptors with ‘tools’ to use when teaching/instructing/demonstrating things to medical students and residents—such as how to implement ‘case based teaching’. Other sessions provided preceptors with ‘principles of effective teaching’—e.g., things to consider when providing feedback to medical students and residents. RPM personnel also observed workshop sessions designed to help preceptors develop their own capabilities—such as the ability to conduct research.

3.3.2 Conclusions: RPAP’s Practicing Physician Support Initiatives

There are six key conclusions we can draw from our findings in this section:

1. The Medical Information Service/Virtual Library is a significant support to practicing physicians. By providing access to up-to-date medical information, rural physicians feel confident that they are able to effectively address the health needs of their patients through the use of ‘best practice’.
2. Rural physicians have limited access to Royal College Re-entry positions. Individuals, who have been able to take advantage of this program, have received significant benefit. However, dedicated, ongoing positions are required if this initiative is going to be a meaningful support for a large number of rural physicians.
3. There is a lack of promotion and uptake of the Rural Physician Innovation/Retention Grants Program.
4. The Award of Distinction Initiative provides an avenue to extol the accomplishments of all rural family physicians who provide their communities with outstanding medical services and, who also make significant contributions to the practice of medicine and their communities, by teaching other medical personnel, conducting research or working as community volunteers. Award recipients can inspire others to reach their potential. The Award of Distinction also provides an opportunity for a community to honour the devoted service it has received from the selected physician.
5. The Enrichment Program has helped many physicians to gain new skill, thereby increasing their capacity to meet the medical needs of their communities.
6. RPAP’s support has helped the UofC and UofA to design and deliver faculty development programs which have increased the teaching skills of rural and regional preceptors. Ultimately, medical students and residents are the real beneficiaries of increases in ‘preceptor teaching proficiency’.

3.3.3 Recommendations: RPAP's Practicing Physician Support Initiatives

RECOMMENDATION #1:

It is recommended that RPAP continue to work with the Associate Deans of the Postgraduate Medical Education at the UofC and UofA to obtain dedicated Royal College Re-entry positions available to rural physicians.

Explanatory Note:

If it is not possible to obtain a dedicated number of Royal College Re-entry positions available to rural physicians, then the degree of impact of this initiative on retaining rural physicians will be minimal in the future.

If it is possible for RPAP to obtain a dedicated number of Royal College Re-entry positions specifically for rural physicians, then it would make sense for RPAP to increase its promotion of this initiative and clearly articulate the difference between this program and the Enrichment Program.

RECOMMENDATION #2:

It is recommended that RPAP either put greater effort in promoting the Rural Physician Innovation/Retention Grants Program or eliminate it and re-direct the funds to other RPAP 'physician support initiatives'.

3.4 **RPAP'S INITIATIVES FOR SUPPORTING REGIONAL HEALTH AUTHORITIES AND COMMUNITIES**

This section presents our findings and conclusions respecting the following RPAP 'Regional Health Authorities and Communities Support' initiatives:

- Community development and partnership grants
- Recruitment expense reimbursement program
- Rural Health Week

To assess these initiatives RPM personnel reviewed the literature, and collected information through interviews with Regional Medical Directors, various stakeholders, and organizations who participate in Rural Health Week.

3.4.1 **Findings: RPAP's RHA and Community Support Initiatives**

A. Community Development and Partnership Grants Program

Description of the Community Development and Partnership Grants Program

The Community Development and Partnership Grants Program was developed within the context of RPAP's Rural Retention Action Plan. In 2001, RPAP convened a multi-stakeholder meeting, attended by 20 representatives, to develop an 'Action Plan' for the retention of rural physicians. Participants felt that a top priority was to work with communities and involve them in developing ways to ease physicians and their families into the community (recruitment) and keep them content with staying there (i.e., retention).

The concept of 'community development' underpins the Community Development and Partnership Grants Program, which was launched in 2002/03. The purposes of this RPAP initiative are to foster the development of:

- Community-Regional Health Authority-local physician relationships;
- a comprehensive Community-RHA recruitment and retention plan; and
- materials required as part of the plan, such as pamphlets/information sheets/CDs, or other activities as outlined in the plan.

Grants are limited to \$5,000 per Community-RHA-local physicians' partnership (including up to \$1,000 toward the development of a plan), and to a maximum of \$10,000 per RHA. Communities are eligible for one grant in a three-year period.

Each application must be accompanied by:

- a complete and signed application letter from the applicants, which includes:
 - ⇒ identifying the partners included in the project
 - ⇒ describing the process by which a recruitment and retention plan will be developed (if one doesn't already exist) as Phase I
 - ⇒ describing the materials to be produced and other potential activities to be included in the plan (to be provided as Phase II if a plan doesn't already exist)
 - ⇒ identifying the financial and in-kind contributions of the partners
 - ⇒ explaining why the proposal should be supported and how it will be maintained after RPAP funding

- if already available, a copy of the Community-RHA recruitment and retention plan that incorporates these materials to be produced or other activities involved;
- a letter of support from the Regional Medical Director
- a budget indicating all projected expenditures and other income sources.

The grants are intended to provide one-time funding for the development of Community-RHA recruitment and retention materials or other activities that are determined to be required as part of a comprehensive recruitment and retention plan.

RPAP's Rural Physician Consultants facilitate and assist with the development of a comprehensive Community-RHA recruitment and retention plan for those communities in which one does not already exist. Examples of 'best practices' from other communities are available as a resource. The Rural Physician Consultants are also available for assistance to communities in which a plan already exists.

The Community Development and Partnership Grants were introduced as part of a community development recruitment and retention strategy. They are to be implemented with the assistance of the RPAP Rural Physician Consultants, who were introduced in the Spring of 2001. Work, in conjunction with Alberta Community Development, to develop, test and complete necessary instruments for a community recruitment and retention "tool kit" in actual communities began in 2002. The RPAP Orientation Guide (2002) was the first component of this "tool kit" followed by the Physician Recruitment and Retention Resource Guide (2004) and with the rest of the "tool kit" to be completed by October 2005.

Effectiveness of the Community Development and Partnership Grants Program

Assessing the effectiveness of RPAP's Community Development and Partnership Grants Program requires an understanding of 'community development'. Community development is a process which entails the mobilization, participation and involvement of local people on common issues important to them. RPAP's recently completed Rural Alberta Resource Guide, which is part of the community recruitment and retention "tool kit" provides advice to RHAs and rural communities respecting the recruitment and retention of physicians, uses a 'community development' approach. For example, it states that "one of the most important building blocks for physician recruitment and retention is a strong group of citizens and community leaders to initiate the process . . . and engage others in developing a 'community recruitment and retention action group'."

RPAP's 'community development approach' is consistent with findings from the literature. For example, Shannon (2003)¹⁹, when discussing the effectiveness of West Virginia's Recruitable Community Project (RCP) points out that the RCP design is based on the following assumptions:

- health care personnel are attracted by a community's physical attractiveness, local supports for the practice and family, and the welcome they feel;
- communities do not understand what health care personnel are looking for or how their community is perceived by potential recruits;
- communities can learn and can effect positive changes;

19. Shannon, K.C, A community development approach to rural recruitment. *Journal of Rural Health* 2003: 19 (Suppl) 347-353.

- outside assistance from trusted in-state resources can provide this needed assistance;
- assistance is best delivered in a supportive and collaborative fashion; and
- an explicit recruitment plan serves as a good vehicle through which to focus the community's efforts.

Shannon reports that within the first year of participation in the Recruitable Community Project, the seven communities involved in this initiative recruited a total of 27 health care providers—including 14 physicians, 6 nurse practitioners, and 7 physician assistants.

Similarly, Felix et al. (2003)²⁰ discuss the Arkansas Delta's use of a 'regional recruiter' whose scope of work is broader than that of a more traditional "professional" recruiter, which usually only involves soliciting candidates for an open position. Felix and her colleagues note that "the Arkansas Delta recruiter uses a holistic approach to recruitment and retention that involves coupling traditional recruitment activities with community development activities. These community development activities involve the mobilization of community members through cooperation and collaboration." This approach has been successful in recruiting several health care providers and has been replicated in other parts of the United States such as Louisiana and Texas.

The following are some specific examples of the activities of the Arkansas Delta Regional Recruiter:

- working with local residents, primary care providers and health care facilities to design and implement community improvements that make the area more attractive to new and existing health care professionals;
- providing technical assistance to enhance local capacity to self-assess needs and map resources;
- guiding action groups in developing strategic plans to address identified needs and build on identified assets;
- nurturing new health care providers to ease their transition into their new community; and
- linking new health care professionals with resources to improve practice retention.

The work of Shannon and Felix et al. reflect RPAP's approach in the design of the Community Development and Partnership Grants Program. This initiative has been designed to facilitate community mobilization, not only through the provision of financial resources, but also through the assistance of RPAP's Rural Physician Consultants.

The Rural Physician Consultants perform many of the same functions as the 'Regional Recruiter' discussed by Felix and her colleagues. As noted earlier, as part of Community Development and Partnership Grants Program, RPAP's Rural Physician Consultants will facilitate and assist with the development of a comprehensive Community-RHA recruitment and retention plan, as well as its implementation.

20. Felix, H, Shepherd, J, Stewart, K.M, Recruitment of rural health care providers: A regional recruiter strategy. *Journal of Rural Health* 2003: 19 (Suppl) 340-346.

The design of RPAP's Community Development and Partnership Grants Program is also consistent with the recently announced Alberta Rural Development Strategy—in which the government's role is to create a positive environment for rural development and to work with rural communities to support locally developed initiatives, plans and projects. That is, through the Community Development and Partnership Grants Program, RPAP can facilitate and enable community mobilization to address physician recruitment and retention issues.

When the RPAP Rural Physician Consultants work with community groups to address physician recruitment and retention issues, they often utilize the expertise of facilitators from Alberta Community Development (ACD). RPM personnel interviewed two individuals from ACD respecting the utility of this approach. Both individuals noted that because Alberta Community Development provides the facilitators, the RPAP Rural Physician Consultants are able to participate in the meeting and directly contribute ideas to address emergent issues. This helps the community groups to effectively work toward developing solutions to deal with identified problems/concerns.

As noted earlier, RPAP launched the Community Development and Partnership Grants Program in 2002/03 to be part of a community recruitment and retention "tool kit", which is just now finishing community testing. To date, RPAP has received only one application under the Community Development and Partnership Grants Program, and that request for funding was approved. RPAP expects more applications as the community recruitment and retention "tool kit" is widely and formally deployed.

B. Recruitment Expense Reimbursement Program

Description of the Recruitment and Expense Reimbursement Program

The purpose of the Recruitment Expense Reimbursement Program is to support rural physician recruitment by reimbursing some of the expenses incurred by rural RHAs and newly recruited physicians.

Specifically, RPAP will:

- reimburse rural RHAs, the recruiting practice, or the recruiter as appropriate for interview expenses (airfare, accommodation, ground transportation, and meals) to a maximum of \$3,000 per interviewed recruit (recent Alberta trainee or physicians outside of Alberta).
- as per Exhibit 18 provide an honorarium to:
 - ⇒ a newly recruited rural physician (including locums) required by the College of Physicians and Surgeons of Alberta (CPSA) to undergo a period of assessment as a condition of approving basic licensure and additional privileges (i.e., GP anaesthesia, GP surgery).
 - ⇒ a newly recruited rural physician required by the College of Physicians and Surgeons of Alberta (CPSA) to undergo a period of assessment as a condition of approving privileges for additional privileges (i.e., GP anaesthesia, GP surgery).
 - ⇒ a currently practicing rural physician required by the CPSA to undergo a period of assessment as a condition of approving additional privileges.

Effectiveness of the Recruitment and Expense Reimbursement Program

The assessment element of the Recruitment Expense Reimbursement Program is accessed through the two RPAP Skills Brokers. These individuals arrange for training and/or assessment of physician to enable individual physicians to attain licensure and/or additional privileges. This involves finding appropriate assessors and having the assessors prepare a suitable training program for an individual physician who will meet the credentialing requirements of the College of Physicians and Surgeons of Alberta. The Skills Brokers also ensure the preceptors prepare reports which indicate the physician's level of proficiency in the skill area. The interview expense reimbursement component is accessed directly through the RPAP office using an on-line application.

Between 1999/00 and 2004/05, RPAP has expended more than \$930,000 through its Recruitment Expense Reimbursement Program. As indicated in Exhibit 18, in the first four years of this initiative, most of the expenditures were for reimbursement of 'interview' expenses. In the past two years (2003/04 and 2004/05), a large percentage of the expenditures related to assessment of physician skills (i.e., 'assessment' and 'preceptor' reimbursement).

EXHIBIT 18

EXPENSES INCURRED—THE RECRUITMENT EXPENSE REIMBURSEMENT PROGRAM

Expense Item	1999-2000	2000-01	2001/02	2002/03	2003/04	2004/05
Interview Expense	63%	61%	83%	45%	31%	11%
Assessment Expense	37%	26%	12%	44%	44%	37%
Preceptors Expense	0%	13%	5%	7%	25%	53%
Other Type of Expense (ATLS)	0%	0%	0%	4%	0%	0%
Total	100%	100%	100%	100%	100%	100%

C. Rural Health Week Initiative

Description of the Rural Health Week Initiative

Rural innovation, success stories and quality skills are celebrated each year during the third week of June through **Rural Health Week** in Alberta. This special week originated through the RPAP in 2002 and is the result of the collaboration of the RPAP and representatives from many provincial and regional rural health interests. Rural Health Week provides an annual focus to raise awareness and showcase some of the unique positive contributions and skills of rural health professionals and organizations. Thereby building stronger connections between health care providers and the communities they serve.

The RPAP Communications Consultant is responsible for all of the communication and marketing/promotion of Rural Health Week. This involves chairing a monthly teleconference with about 40 participating organizations, working extensively with various media outlets, and posting stories on the Rural Health Week web site.

Effectiveness of Rural Health Week

In February 2005 the Alberta Government released the Alberta Rural Development Strategy, and Rural Health Week is congruent with and supportive of this provincial initiative which outlines objectives and actions to be taken to strengthen the four pillars essential for sustainable rural communities:

- Economic growth – providing opportunities for rural communities to develop strong economies and benefit fully from the Alberta Advantage.
- Community capacity, quality of life and infrastructure – ensuring that rural communities have the capacity, the quality of life, and the infrastructure necessary to remain vibrant and attractive places to live, work and visit.
- Health care – making sure people in rural Alberta have access to quality health services, recognizing the role rural health regions can play in health renewal, and providing opportunities to develop the economic potential of health care services.
- Learning and skill development – providing excellent schools, access to the best possible education, and expanding opportunities in local communities for people to get the skills they need to compete and succeed in the marketplace.

To assess the effectiveness of Rural Health Week as a celebration of the contributions and skills of rural health professionals and organizations, RPM personnel interviewed individuals from several organizations, including:

- Alberta Association of Registered Nurses;
- Medicine Hat College—Nursing Program;
- University of Lethbridge Health Sciences;
- Northern Lights Regional Health Authority;
- College of Licence Practical Nurses;
- Pharmacists Association of Alberta;
- Aspen Regional Health Authority;
- Alberta Community Development; and
- Alberta Agriculture, Food and Rural Development.

These stakeholders noted the following benefits of Rural Health Week:

- employees across the Region realize they are an important part of a 'health care delivery' team;
- health care providers appreciate the public recognition of their professional contribution to the community;
- it increases awareness of rural life; and
- it increases the awareness among community members of the important contribution made by 'non-physician' health care providers to rural health.

While most stakeholders are uncertain as to whether Rural Health Week has a direct impact on recruitment and retention of rural health care professionals, some stressed that increasing the awareness of the contribution made by rural health care providers may entice more high school students to choose a career in one of the health professions.

Many of the organizations interviewed by RPM personnel stated they appreciate RPAP's role in coordinating the planning of Rural Health Week and all reported they are 'very satisfied' with the performance of the RPAP Communications Consultant.

The RPAP Communications Consultant distributed a survey to the 40 organizations who participated in Rural Health Week in 2004. Eleven responses were received and the data indicate that they all believe Rural Health Week provided a good opportunity to talk about the challenges of rural health service delivery, as well as to showcase the positive contributions of rural health professionals and organizations. In addition, all of the respondents stated they would recommend that their organization continue to participate in Rural Health Week. The following comment from one individual summarizes the perspective of many of the other respondents, "We are a rural health region and our priority is responding to the health needs/concerns of rural Albertans. Rural Health Week helps to get the message out to our rural communities but also to the larger urban centres/health regions."

3.4.2 Conclusions: RPAP's RHA and Community Support Initiatives

There are three key conclusions we can draw from our findings in this section:

1. The Community Development and Partnership Grants Program is congruent with and supportive of the recently announced provincial Rural Development Strategy. This RPAP initiative has the potential, as part of the broader RPAP community development approach to recruitment and retention, to be of significant value to rural communities in identifying barriers to recruitment and retention of physicians, and determining and implementing solutions. This initiative has the potential of building stronger relationships between rural physicians and their communities. The RPAP Rural Physician Consultants' application of a 'community development' approach is instrumental in building a community's capacity to find ways to retain their current physicians and recruit others.
2. The Recruitment Expense and Reimbursement Program has been used extensively since the initiative was launched in 1999/2000. It effectively addresses both 'recruitment' and 'retention' of physicians. The program has been used extensively to offset the costs of 'recruiting' rural physicians (e.g., interview expenses), as well as for the assessment of skills of newly recruited physicians, and for currently practicing rural physicians respecting additional privileges (i.e., retention). The RPAP Skills Brokers are instrumental in the implementation of this initiative for the assessment aspect of the Program.
3. Rural Health Week is congruent with and supportive of the Alberta Rural Development Strategy. Participating organizations believe it has significant benefit and is achieving its goal of providing a good opportunity to talk about the challenges of rural health service delivery, as well as showcasing the positive contributions of rural health professionals and organizations.

3.4.3 Recommendations: RPAP's RHA and Community Support Initiatives

There are no recommended changes.

3.5 THE RURAL PHYSICIAN SPOUSAL NETWORK

This section presents our findings and conclusions respecting the Rural Physician Spousal Network (RPSN). To assess this initiative RPM personnel reviewed the literature, and the published information about the RPSN, including the evaluation conducted by RPM in 2003/04.

3.5.1 Findings: Rural Physician Spousal Network

Description of the Rural Physician Spousal Network

The RPSN concept originated at an October 1998 focus group of rural physician spouses hosted by the Alberta Medical Association (AMA). The participants recognized the importance of spousal satisfaction as a factor related to the retention of rural physicians and a Rural Partners Action Committee (RPAC) was formed. The RPAC sought Rural Physician Action Plan (RPAP) support and was funded beginning in the Fall of 1998, as the RPAP Coordinating Committee recognized the importance of spouses and families in decisions related to the recruitment and retention of rural physicians.

In 2000, the RPAC changed its name to the Rural Physician Spousal Network (RPSN), and through the RPAP, hired its first Administrator to support the work of the Network and its Advisory Committee.

Up until January 2005, the Rural Physician Spousal Network operated autonomously yet cooperatively with the RPAP. That is, the RPSN received an annual grant from the RPAP and functioned independently, providing monthly activity reports and an annual report and financial summary. The RPSN hired and supervised its Administrator. The Administrator and volunteer Treasurer looked after the budget, including accounts payable and receivable.

In December 2004, the RPAP Coordinating Committee approved changes to manage the operations of the Network directly. In addition, TT Communications prepared a work plan at the request of the RPAP Program Manager to guide the Network's future operations and growth as part of a new service delivery model. The Program Manager intends to work within the broad direction of the work plan. This general approach was endorsed by the RPAP CC in June 2005 with a one-year time frame to demonstrate success.

Effectiveness of the Rural Physician Spousal Network

The evaluation of the Rural Physician Spousal Network conducted by RPM in 2003/04 found that the RPSN needed to increase its reach to the community of 'rural physician spouses'. The evaluation suggested this should be accomplished by direct one-to-one discussion—either through friends, a Network representative, or another physician's spouse.

The 2003 RPSN evaluation showed that newcomers and IMGs are more likely to be socially isolated and would benefit from support through the Rural Physician Spousal Network. Other high-risk sectors that would benefit from support, identified through the evaluation, are:

- two-career families;
- career-on-hold spouses;
- families with children; and
- residents.

Several stakeholders interviewed by RPM personnel as part of the evaluation of RPAP suggested that the Rural Physician Spousal Network needs to be strengthened or discontinued. One approach to changing the Network requires conceptualizing the RPSN differently. Using a 'community development' approach, one could conceive of physicians' spouses as a 'community'—not in a geographic sense, but rather as a network/community of spouses who support one another.

A community development approach calls for greater participation of the 'community members'. It also permits community members to assume a greater degree of control over their lives and the future of their community. Conceptualizing the RPSN in this way would lead one to find ways to strengthen this 'community' and to make it more self-reliant.

Thus, programming and services for both at-risk and established spouses could focus around the determinants of rural "fulfillment and satisfaction" that are within the RPSN's influence, such as social connectedness and sense of belonging, connection with others who have similar needs or issues. Welcoming newcomers would be another initiative that could be undertaken by members of the Rural Physician Spousal Network to increase the resiliency of physicians' spouses and ease their transition to rural living.

As noted earlier, the literature indicates that a physician's spouse has significant influence in where a physician ultimately practices. Moreover, data from the RPAP Recruitment Fairs showed that 58% of residents and 65% of medical students respectively indicated that 'where their spouse wants to live' is a contributing factor to where they will choose to practice. Furthermore, 68% of residents and 77% of medical students who had attended the RPAP Recruitment Fairs noted that 'employment opportunities for my spouse', is also a factor which would influence where they will chose to practice. Within this context the Network has significant potential to affect physician recruitment and retention.

3.5.2 Conclusions: Rural Physician Spousal Network

There are two key conclusions we can draw from our findings in this section:

1. A physician's spouse has significant influence over where the individual practices. Therefore, the Rural Physician Spousal Network has great potential to affect physician recruitment and retention.
2. The new conceptual framework for the Rural Physician Spousal Network should be implemented and assessed by 31 March 2006.

3.5.3 Recommendations: Rural Physician Spousal Network

RECOMMENDATION #1:

It is recommended that RPAP implement the new conceptual framework for the Rural Physician Spousal Network including the associated work plan. This work plan should guide the work of the RSPN, as well as its management and administration. The continuation of the Network should be assessed based on the work plan by 31 March 2006.

4.0 EFFECTIVENESS OF RPAP'S INITIATIVES ON RECRUITMENT AND RETENTION OF RURAL PHYSICIANS

Based on our analysis of the collected information, RPAP's recruitment and retention initiatives, for the most part seem to be working reasonably well—although some changes have been recommended to a few of these programs. However, the critical question remains, has RPAP's initiatives, collectively, facilitated recruiting physicians to rural Alberta and facilitated their retention?

The RPAP's recruitment and retention initiatives must be presented in the context that no single organization, neither can be nor is, solely responsible for effective recruitment and retention of rural physicians. As the RPAP business plan states: "The recruitment and retention of physicians is a "complex interplay" of many variables not all of which the RPAP can influence."

However, within its sphere of influence, RPM personnel analyzed data from the following sources and our findings are presented in the next several sections:

- RPAP's Physician database;
- Canadian Post-M.D. Education Registry (CAPER) data from the University of Alberta;
- a report prepared by the University of Calgary respecting the location of graduates from its Family Medicine Program.

4.1 EFFECTIVENESS OF RPAP ON RECRUITMENT OF RURAL PHYSICIANS

4.1.1 Findings: Effectiveness of RPAP on the Recruitment of Rural Physicians

Five of the nine Regional Health Authorities have a Regional Hospital which provides tertiary level care. These communities are often referred to as Regional Centres. Exhibit 19 presents information for those RHAs which have a Regional Centre (Chinook, Palliser, David Thompson, Peace and Northern Lights).

There are two parts to Exhibit 19. Part A shows that *prior* to the inception of RPAP in 1990:

- physicians were concentrated in the Regional Centres and this historical pattern has not changed because specialist physicians are required to deliver services at the Regional Hospitals; and
- there was a greater proportion of Family Practitioners located in communities outside the Regional Centres and this historical pattern has not changed.

The data in Part A of Exhibit 19 also show that *since the inception of RPAP* there has been a decline in specialists located in communities outside the Regional Centres. This is predominantly related to centralization in the health care delivery infrastructure which commenced shortly after regionalization in 1994.

Part B of Exhibit 19 shows that between 1990-97 and 1998-2004 there has been:

- a 16% increase in the average number of physicians, in any one year, who were located in Regional Centres versus a 6% increase in the average number of physicians in any one year, in smaller rural communities; and
- twice as much growth in the number of *Family Practitioners*, in any one year, who located in Regional Centres compared to those who chose to practice in smaller rural communities, in any one year (12% versus 6%—see bottom of Part B).

EXHIBIT 19

PERCENT OF PHYSICIANS IN REGIONAL CENTRES VERSUS RURAL COMMUNITIES

Based on the Avg. Number of Physicians Per Year in Each Time Period	Part A			Part B		
	1986 to 1989 (Pre-RPAP)	1990 to 1997 *	1998 to 2004	Avg. Number of Physicians Per Year	Avg. Number of Physicians Per Year	Percent Change
	Time Period 1	Time Period 2	Time Period 3	Time Period 2	Time Period 3	Time 2 and Time 3
Physicians (Specialists and Family Practitioners) In Chinook, Palliser, David Thompson, Peace, and Northern Lights Regions						
Regional Centres	56%	59%	61%	430	500	16%
Rural Communities	44%	41%	39%	300	319	6%
Total	100%	100%	100%	730	819	12%
Specialists In Chinook, Palliser, David Thompson, Peace, and Northern Lights Regions						
Regional Centres	82%	88%	89%	208	252	21%
Rural Communities	18%	12%	11%	28	31	11%
Total	100%	100%	100%	236	283	20%
Family Practitioners In Chinook, Palliser, David Thompson, Peace, and Northern Lights Regions						
Regional Centres	45%	45%	46%	222	248	12%
Rural Communities	55%	55%	54%	272	288	6%
Total	100%	100%	100%	494	536	9%

* Pre-recruitment Initiative undertaken by RPAP in 1998.

Recruitment of Family Practitioners to Rural Alberta

The following Exhibit shows:

- there has been an increase in the number of Family Practitioners located in rural Alberta since the inception of RPAP in 1990; and
- all Regions benefited from the special recruitment initiative undertaken by RPAP in 1998 at the request of Alberta Health and Wellness.

EXHIBIT 20

AVERAGE ANNUAL NUMBER OF FAMILY PRACTITIONERS IN RURAL ALBERTA

Avg. Number of Family Practitioners Per Year in Each Time Period	1986 to 1989 (Pre-RPAP)	1990 to 1997 *	Percent Change	1998 to 2004	Percent Change
	Time Period 1	Time Period 2	Time 1 and Time 2	Time Period 3	Time 2 and Time 3
Region 1: Chinook Rural	48	52	8%	50	-4%
Lethbridge	65	67	3%	76	13%
Region 2: Palliser Rural	18	21	17%	22	5%
Medicine Hat	33	37	12%	41	11%
Region 3: Calgary Rural	85	87	2%	120	38%
Region 4: David Thompson Rural	135	144	7%	160	11%
Red Deer	57	57	0%	64	12%
Region 5: East Central Rural	79	76	-4%	83	9%
Region 6: Capital Rural	54	56	4%	72	29%
Region 7: Aspen Rural	111	118	6%	139	18%
Region 8: Peace Country Rural	46	45	-2%	46	2%
Grande Prairie	29	35	21%	40	14%
Region 9: Northern Lights Rural	12	10	-17%	10	4%
Fort McMurray	24	26	8%	27	4%

* Pre-recruitment Initiative undertaken by RPAP in 1998.

Between 1986 and 2004, there has been a 78% increase in the number of Family Practitioners to rural Alberta (from 799 to 1,424). The following Exhibits show that since the inception of RPAP in 1990, the percent of in-migration of Family Practitioners to rural communities in most years has been greater than the percent of out-migration, resulting in a net gain of Family Practitioners to rural Alberta.

The Exhibits also show that the percentage of out-migration of Family Practitioners from rural Alberta has risen substantially in 2004. Accordingly, it appears as though the major increase to the fee schedule (approximately 24%) contained in the AMA/Alberta Health and Wellness Master Agreement which covered the fiscal years 2001/02 and 2002/03, had a limited effect on recruitment and retention of Alberta rural Family Practitioners.

These data indicate that until recently, RPAP's initiatives have had a positive effect on facilitating the retention of rural Family Practitioners.

EXHIBIT 21

PERCENTAGE OF IN/OUT MIGRATION OF FAMILY PRACTITIONERS TO RURAL ALBERTA

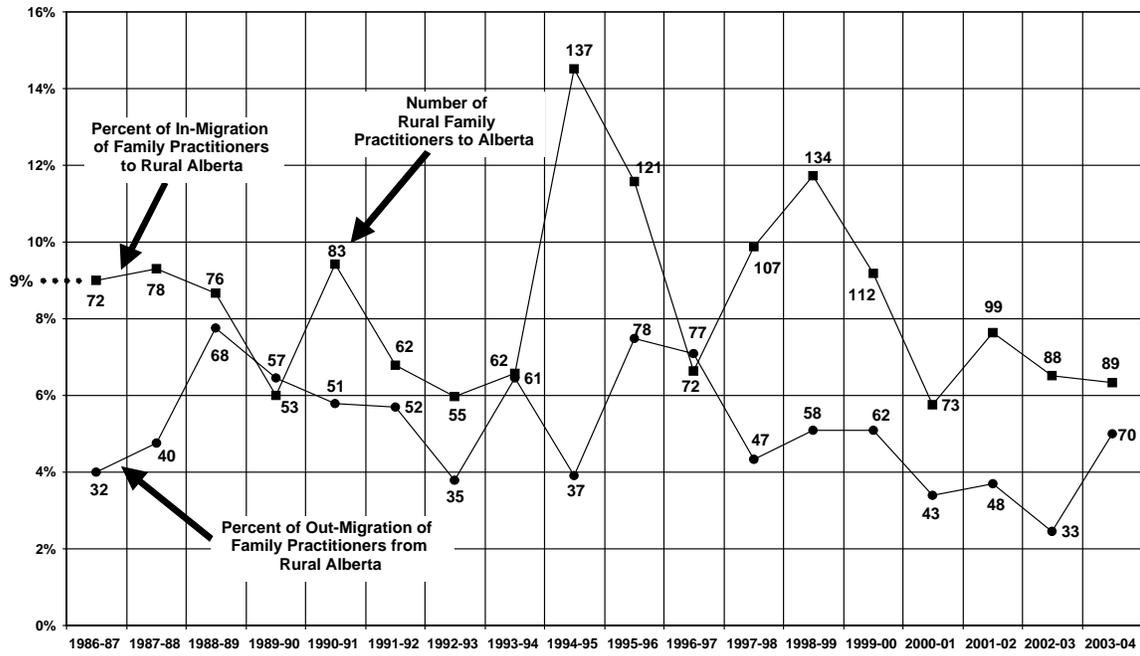
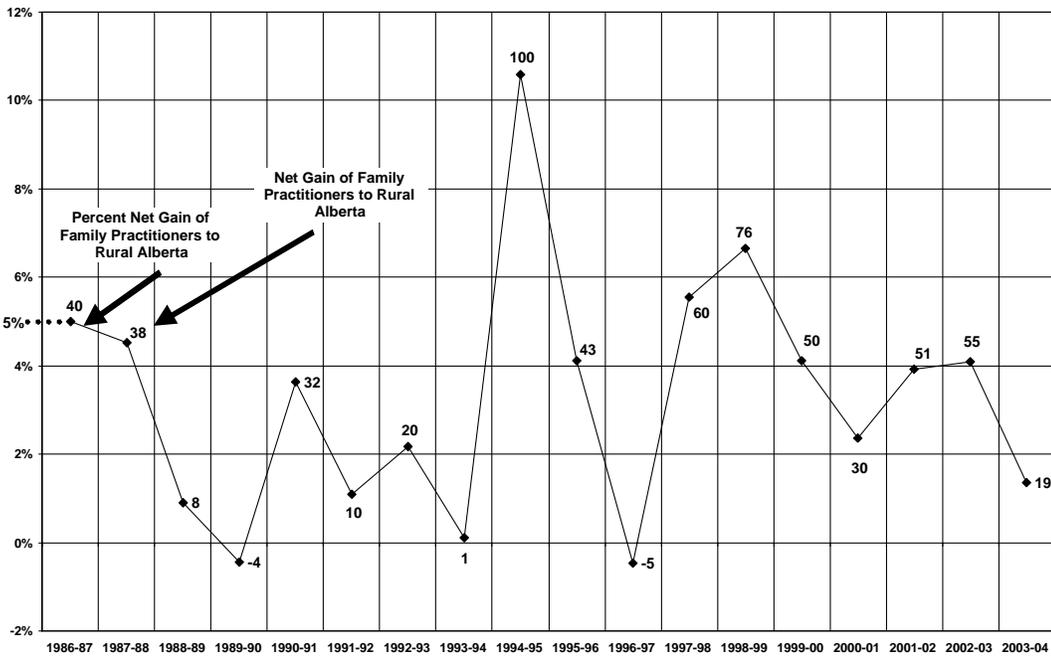


EXHIBIT 22

NET GAIN OF FAMILY PRACTITIONERS TO RURAL ALBERTA



Recruitment of Specialists to Rural Alberta

The following Exhibit shows:

- there has been an increase in the number of Specialists located in rural Alberta since the inception of RPAP in 1990; and
- all Regions benefited from the special recruitment initiative undertaken by RPAP in 1998 at the request of Alberta Health and Wellness.

EXHIBIT 23

AVERAGE ANNUAL NUMBER OF SPECIALISTS IN RURAL ALBERTA

Avg. Number of Specialists Per Year in Each Time Period	1986 to 1989 (Pre-RPAP)	1990 to 1997 *	Percent Change	1998 to 2004	Percent Change
	Time Period 1	Time Period 2	Time 1 and Time 2	Time Period 3	Time 2 and Time 3
Region 1: Chinook Rural	9	9	0%	7	-22%
Lethbridge	63	76	21%	85	12%
Region 2: Palliser Rural	4	2	-50%	2	0%
Medicine Hat	31	37	19%	45	22%
Region 3: Calgary Rural	7	14	100%	24	71%
Region 4: David Thompson Rural	21	15	-29%	19	27%
Red Deer	54	67	24%	82	22%
Region 5: East Central Rural	16	12	-25%	15	25%
Region 6: Capital Rural	3	4	33%	6	50%
Region 7: Aspen Rural	13	11	-15%	11	0%
Region 8: Peace Country Rural	3	2	-33%	2	0%
Grande Prairie	14	19	36%	28	47%
Region 9: Northern Lights Rural	0	0	0%	1	<1%
Fort McMurray	10	9	-10%	12	33%

* Pre-recruitment Initiative undertaken by RPAP in 1998.

Between 1986 and 2004, there has been a 94% increase in the number of Specialists to rural Alberta (from 246 to 477). The following Exhibits show that since the inception of RPAP in 1990, the percent of in-migration of Specialists to rural communities in most years has been greater than the percent of out-migration, resulting in a net gain of Specialists to rural Alberta.

The Exhibits also show that the percentage of out-migration of Specialists from rural Alberta has risen substantially in 2004. Accordingly, it appears as though the major increase to the fee schedule (approximately 24%) contained in the AMA/Alberta Health and Wellness Master Agreement which covered the fiscal years 2001/02 and 2002/03, had a limited effect on recruitment and retention of Alberta rural Specialists.

These data indicate that until recently, RPAP's initiatives have had a positive effect on facilitating the retention of rural Specialists.

EXHIBIT 24
PERCENTAGE OF IN/OUT MIGRATION OF SPECIALISTS TO RURAL ALBERTA

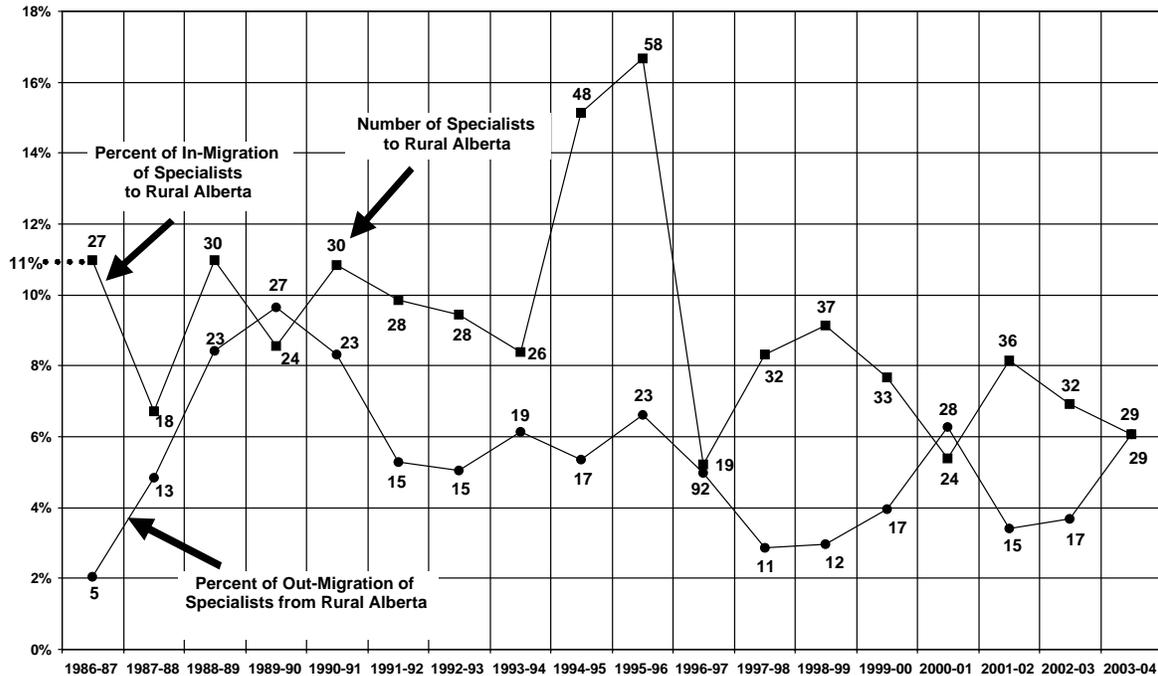
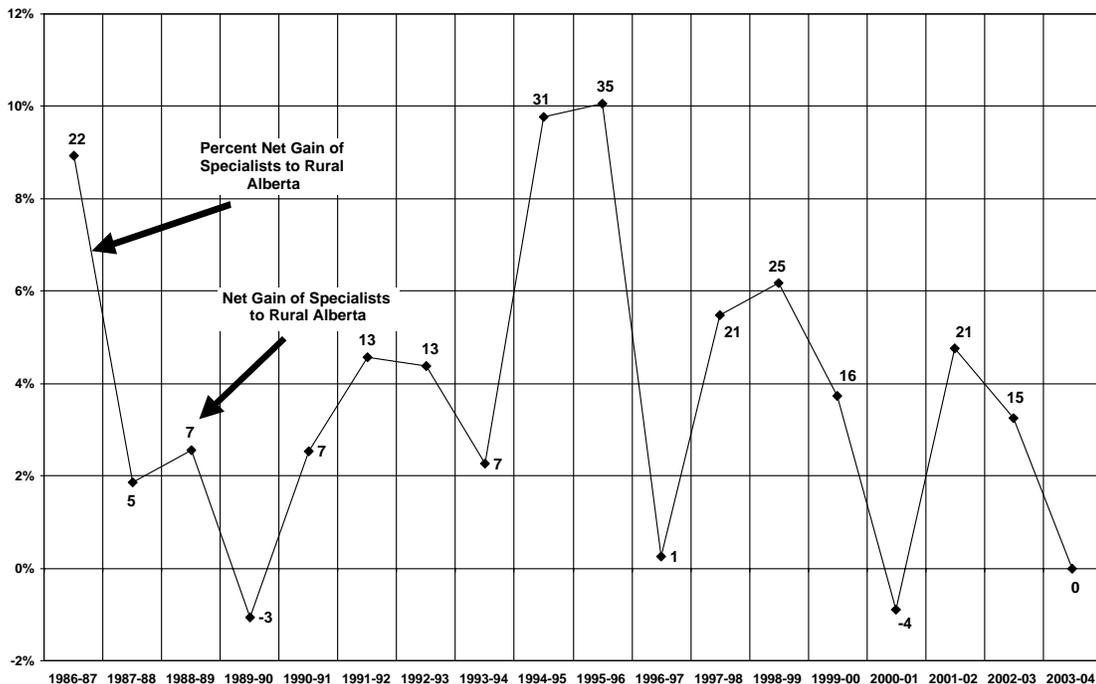


EXHIBIT 25
NET GAIN OF SPECIALISTS TO RURAL ALBERTA



Recruitment of Physicians to Rural Alberta (Family Practitioners and Specialists)

The following Exhibit shows:

- there has been an increase in the number of physicians (Family Practitioners and Specialists) located in rural Alberta since the inception of RPAP in 1990; and
- all Regions benefited from the special recruitment initiative undertaken by RPAP in 1998 at the request of Alberta Health and Wellness.

EXHIBIT 26

AVERAGE ANNUAL NUMBER OF PHYSICIANS IN RURAL ALBERTA

Avg. Number of Physicians Per Year in Each Time Period (Family Practitioners and Specialists)	1986 to 1989	1990 to 1997 *	Percent Change	1998 to 2004	Percent Change
	(Pre-RPAP) Time Period 1	Time Period 2	Time 1 and Time 2	Time Period 3	Time 2 and Time 3
Region 1: Chinook Rural	57	61	8%	57	-7%
Lethbridge	128	143	11%	161	12%
Region 2: Palliser Rural	22	23	6%	24	6%
Medicine Hat	64	74	16%	86	16%
Region 3: Calgary Rural	92	101	10%	144	43%
Region 4: David Thompson Rural	156	159	2%	179	13%
Red Deer	111	124	12%	146	18%
Region 5: East Central Rural	95	88	-7%	98	11%
Region 6: Capital Rural	57	60	5%	78	30%
Region 7: Aspen Rural	124	129	4%	150	16%
Region 8: Peace Country Rural	49	47	-4%	48	2%
Grande Prairie	43	54	26%	68	26%
Region 9: Northern Lights Rural	12	10	-16%	11	17%
Fort McMurray	34	35	3%	39	12%

* Pre-recruitment Initiative undertaken by RPAP in 1998.

Between 1986 and 2004, there has been an 82% increase in the number of physicians (Family Practitioners and Specialists) to rural Alberta (from 1,045 to 1,901). The following Exhibits show that since the inception of RPAP in 1990, the percent of in-migration of physicians to rural communities in most years has been greater than the percent of out-migration, resulting in a net gain of physicians to rural Alberta.

The Exhibits also show that the percentage of out-migration of physicians from rural Alberta has risen substantially in 2004. Accordingly, it appears as though the major increase to the fee schedule contained in the AMA/Alberta Health and Wellness Master Agreement which covered the fiscal years 2001/02 and 2002/03, had a limited effect on recruitment and retention of Alberta rural physicians.

These data indicate that until recently, RPAP's initiatives have had a positive effect on facilitating the retention of rural physicians.

EXHIBIT 27

PERCENTAGE OF IN/OUT MIGRATION OF PHYSICIANS TO RURAL ALBERTA

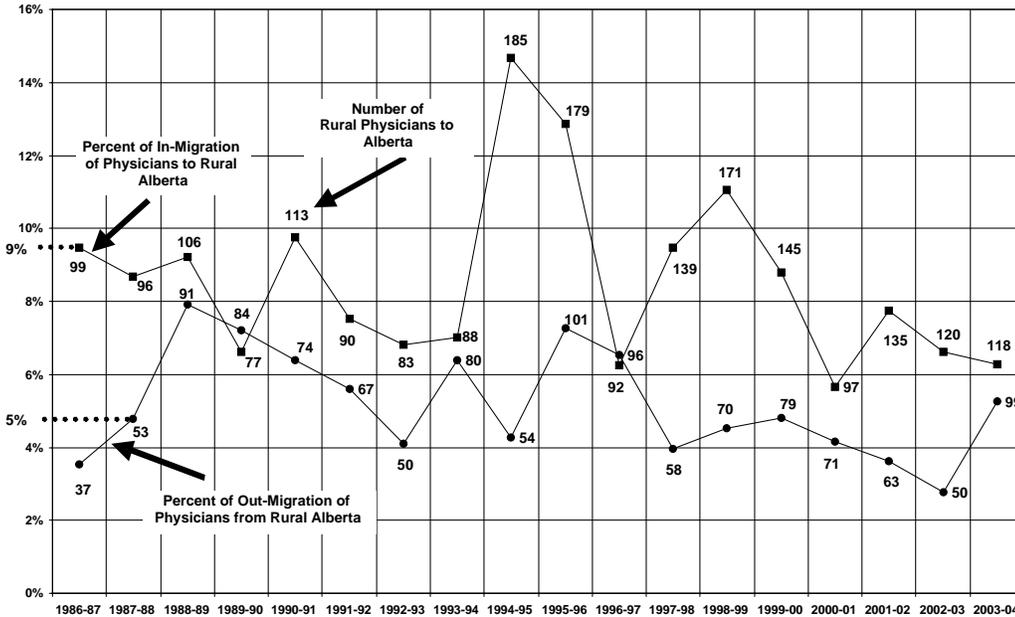
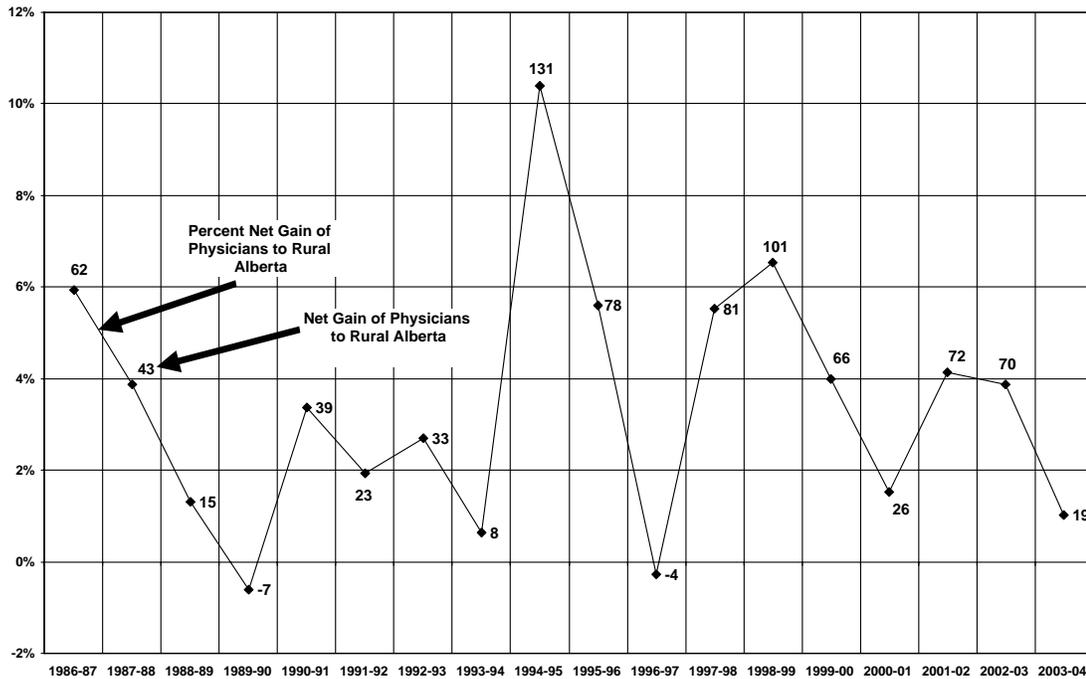


EXHIBIT 28

NET GAIN OF PHYSICIANS TO RURAL ALBERTA



4.1.2 Conclusions: Effectiveness of RPAP on the Recruitment of Rural Physicians

There are three key conclusions we can draw from our findings in this section:

1. RPAP's initiatives have been effective in contributing to the recruitment of physicians to rural Alberta. The in-migration of physicians to rural Alberta has exceeded the out-migration in almost every year since the inception of RPAP in 1991.
2. Prior to the inception of RPAP specialist physicians were concentrated in the Regional Centres primarily because they are required to deliver services at the Regional Hospitals. This historical pattern has not changed and, has been accentuated in recent years. In addition, a greater proportion of Family Practitioners have historically been located in communities outside the Regional Centres and this pattern has not changed.
3. With the exception of a one-time direct recruitment drive, undertaken at the request of Alberta Health and Wellness, RPAP's recruitment initiatives are aimed at supporting the 'direct recruitment efforts' of other stakeholders, and in establishing medical education programs, with appropriate policies, which will expose students and residents to rural medicine in an effort to encourage these individuals to choose rural medicine as a career—i.e., RPAP's education pipeline strategy.

Notwithstanding the positive contribution of RPAP's recruitment initiatives, there is an insufficient number of physicians locating in small/remote rural communities to assist the current cohort of rural physicians with the burden of meeting the health needs of their local residents. More action by RPAP, in conjunction with other stakeholders, is required to address this issue.

4.1.3 Recommendations: Effectiveness of RPAP on the Recruitment of Rural Physicians

RECOMMENDATION #1:

It is recommended that RPAP continue to work with other stakeholders to encourage graduates of the two Alberta medical schools and medical school graduates in general to locate in small/remote Alberta communities.

RECOMMENDATION #2:

It is recommended that RPAP continue to work with other stakeholders to attract physicians from outside the province to locate in small rural/remote communities.

Explanatory Note:

According to the recently announced Alberta Rural Development Strategy, 'rural health' is everyone's business, not just RPAP's and other 'physician-oriented' stakeholders such as the AMA and the College of Physicians and Surgeons of Alberta. The work of the past several years by the RPAP in support of the Rural Development Strategy and the Rural Development Unit of the Ministry of Agriculture, Food and Rural Development is noted and supported.

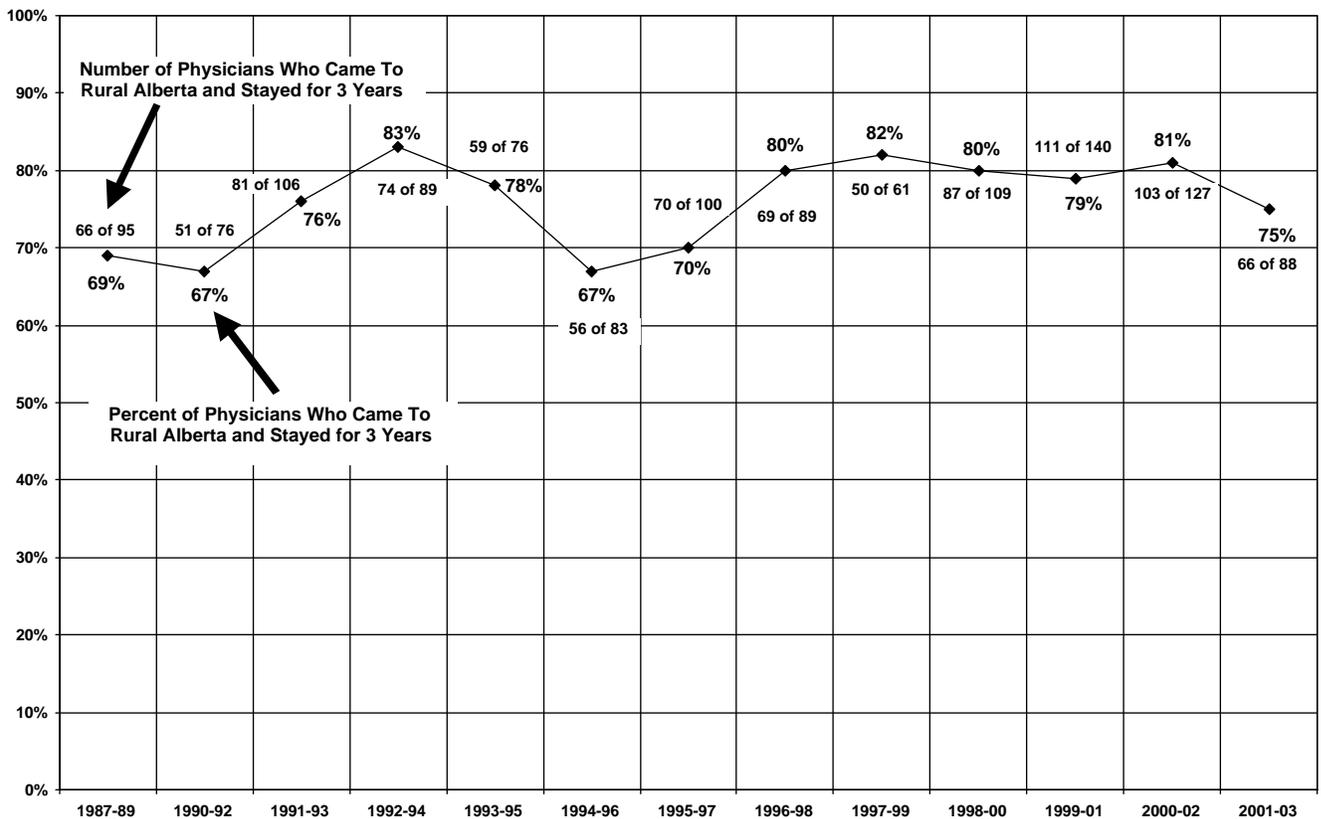
5.1.1 Findings: Effectiveness of RPAP on the Retention of Rural Physicians

In order to determine the effectiveness of RPAP's retention initiatives, we calculated 3-year retention rates for physicians who commenced practice in rural Alberta between 1987 and 2001. This includes graduates from UofA/UofC, as well as physicians from other provinces and countries.

Exhibit 29 indicates that *prior* to the inception of RPAP (pre-1990) and the full development of its retention initiatives (1990-92), less than 70% of the new physicians who commenced practice in rural Alberta stayed for a full 3 years. However, since the inception of RPAP, the 3-year retention rates for new physicians who commenced practice in rural Alberta have been consistently above 75%—with the exception of the time when the health care delivery system was being altered through the establishment of Regional Health Authorities in 1994 and 1995. These data show that RPAP's initiatives have contributed to retaining physicians who have chosen to practice in rural Alberta.

EXHIBIT 29

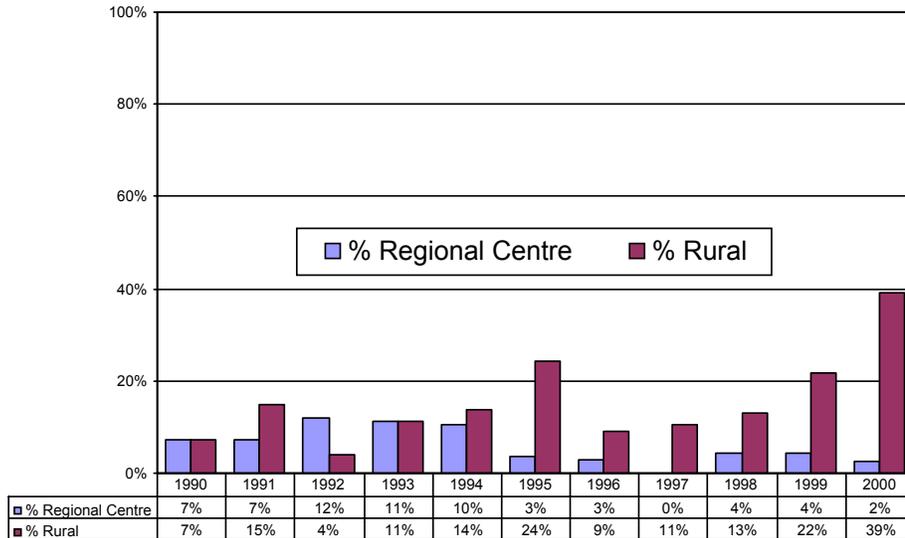
THREE-YEAR RETENTION RATES FOR NEW PHYSICIANS WHO COMMENCED PRACTICE IN RURAL ALBERTA BETWEEN 1987 AND 2001



RPM personnel obtained Canadian Post-M.D. Education Registry (CAPER) data from the University of Alberta Family Medicine Program for the period 1988 to 2004. We used the CAPER data to determine the percentage of graduates from the UofA's 2-year Family Medicine Residency Program that chose to practice in a rural community in Alberta (see Exhibit 30). The data show that the percentage of residents choosing to practice in a rural community has been increasing, while the proportion going to regional centres has been steadily declining. ***These data have to be used with caution because the numbers are quite small—sometimes only 4 residents in a year choosing a 'non-urban' practice site.***

EXHIBIT 30

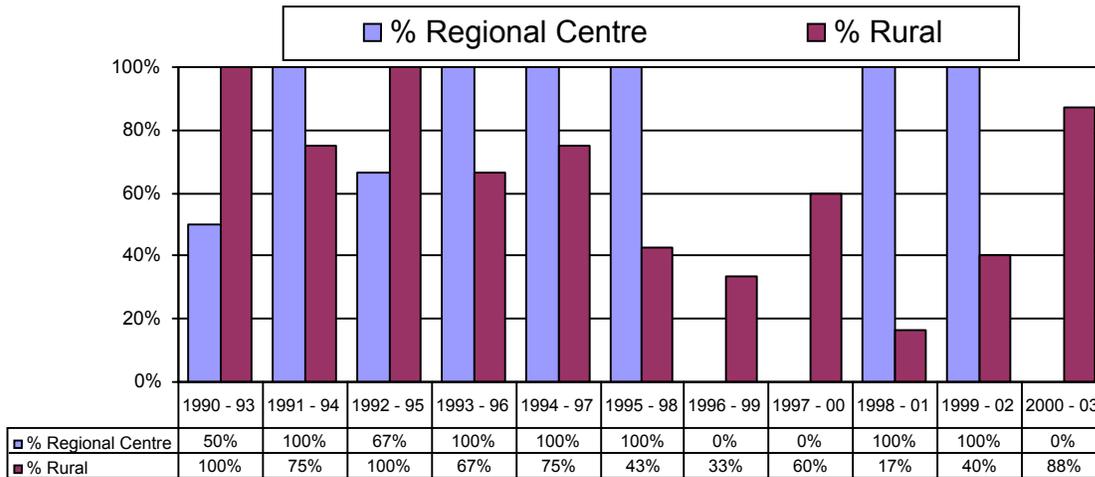
PERCENTAGE OF UofA FAMILY MEDICINE RESIDENTS WHO CHOSE TO PRACTICE IN A RURAL COMMUNITY IN ALBERTA



We also used the CAPER data to calculate 3-year retention rates for these UofA graduates. The data show that a large percentage of these graduates were located in rural Alberta 3 years after residency (see Exhibit 31). The 3-year retention rate is somewhat better in the regional centres compared to small/remote communities.

EXHIBIT 31

THREE-YEAR RETENTION RATES FOR UofA FAMILY MEDICINE RESIDENTS

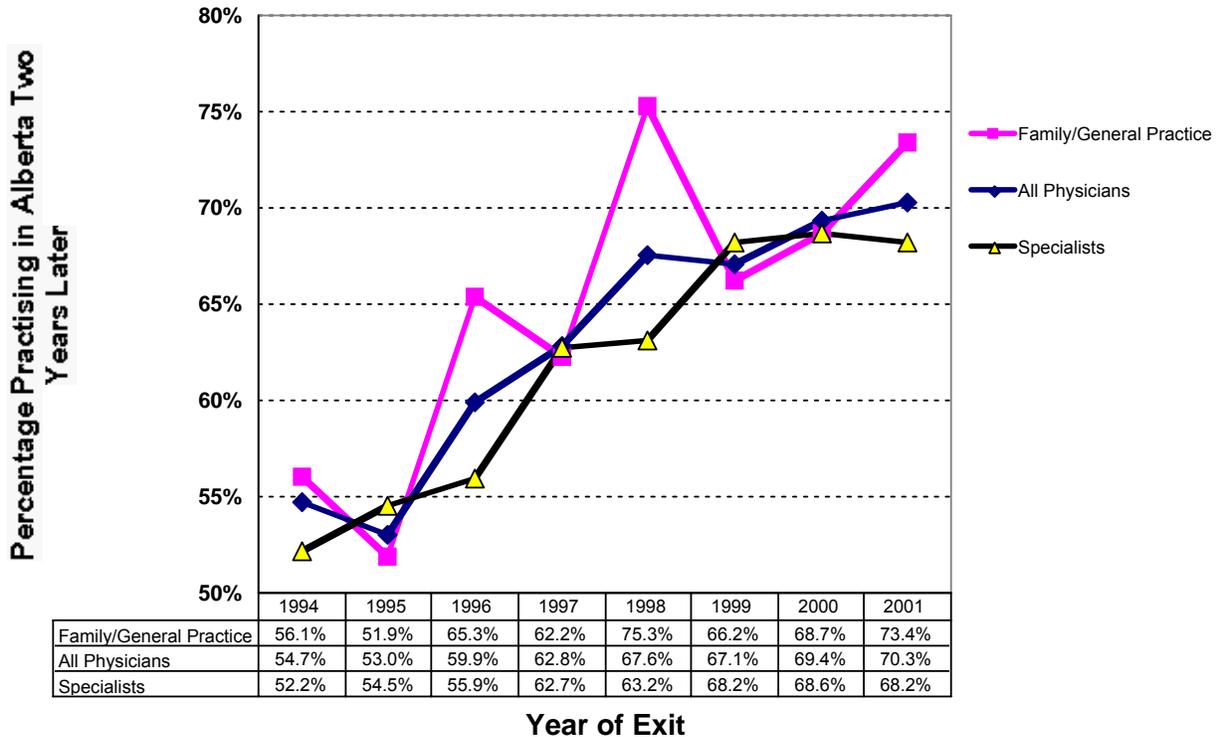


The Canadian Post-M.D. Education Registry (CAPER) does not have historical data for the University of Calgary's Family Medicine Program. However, the UofC did conduct a Family Medicine Graduates Survey, covering the period of 1996 to 2000. The data showed that about one-quarter of the UofC Family Medicine Graduates were practicing in a rural community (<10,000 population).

To put the earlier discussion in a larger perspective, Exhibit 32 indicates that retention rates for 'urban' as well as 'rural/regional' physicians, trained in Alberta, have been increasing over the years. The data show that retention rates for both specialists and Family Practitioners have increased steadily since 1994.

EXHIBIT 32

Retention of Post-M.D. Trainees from Alberta Universities



5.1.2 Conclusions: Effectiveness of RPAP on the Retention of Rural Physicians

There is one key conclusion we can draw from our findings in this section:

1. RPAP's initiatives have been effective in contributing to the retention of physicians in rural Alberta, and guiding residents to rural medicine in an effort to encourage these individuals to choose rural medicine as a career.

5.1.3 Recommendations: Effectiveness of RPAP on the Retention of Rural Physicians

There are no recommended changes.

6.1.1 Findings: Effectiveness of RPAP's Initiatives on the Recruitment and Retention of Rural Physicians Compared With Other Canadian Jurisdictions

One approach to determine the effectiveness of RPAP's initiatives on the recruitment and retention of rural physicians is to compare the Alberta experience with that of other Canadian jurisdictions. The RPAP CC believes that comparing Alberta to British Columbia and Saskatchewan is appropriate.

While this approach seems germane, there are several draw backs to undertaking this comparison. The first involves the definition of 'rural' and 'regional centre'. As noted earlier, many researchers define 'rural' as communities with <10,000 population. However, Dr. Raymond Pong—Research Director of the Centre for Rural and Northern Health Research at Laurentian University in Northern Ontario uses a much finer classification, including:

- large town (20,000 - 24,999);
- small town (5,000 - 9,999);
- small community (2,000 - 4,999); and
- rural area (population less than 2,000).

Without a common definition of 'rural', it is not possible to undertake an accurate multijurisdictional comparison of recruitment and retention of rural physicians. The same issue concerns an examination of recruitment and retention of physicians to 'regional centres'.

Even if the definition of 'rural' was the same in the three jurisdictions—Alberta, British Columbia, and Saskatchewan—it would be necessary to obtain data for all three provinces for the same time period and for the same 'type of physician'—e.g. General Practitioner. Moreover, it would be best if the data came from the same 'type of source'—such as the respective provincial Colleges of Physicians and Surgeons, or the Canadian Institute of Health Information (CIHI). Meeting these conditions would help to ensure the reliability and validity of the information.

RPM personnel were unable to obtain the same type of information from British Columbia or Saskatchewan as exists in the RPAP Physician database and that was presented in the previous sections of this report. Regrettably, Alberta appears to be the only jurisdiction that collects information, on an ongoing basis, about 'physician location'. We attempted to obtain relevant data from B.C. Health and Saskatchewan Health and the CIHI. However, the available data was for 'total' physician counts only, rather than for 'rural', 'regional' and 'urban' communities.

We were able to obtain some literature related to the number of rural physicians in British Columbia. Soles (2001) conducted telephone surveys with physicians living and working in those BC communities previously designated as 'isolated' by the Ministry of Health and the BC Medical Association.²¹ The surveys were conducted at four intervals between 1998 and 1999, and included GPs and specialists.

Soles found that the number of physicians in rural BC fell during the study period—resulting in a net decrease of 1.7%. At the same time, however, there was a 59% increase in the number of rural physicians in Alberta (GPs and specialists)—which to a large extent reflects the pre-recruitment Initiative undertaken by RPAP in 1998, involving the attraction of Canadian and International Medical Graduates to Alberta. This is an inappropriate comparison, and reflects the importance of having comparable data.

21. Soles, T, L, Physician numbers in rural British Columbia. Canadian Journal of Rural Medicine 2001: 6 (1) 24-30.

6.1.2 Conclusions: Effectiveness of RPAP's Initiatives on the Recruitment and Retention of Rural Physicians Compared With Other Canadian Jurisdictions

There is one key conclusion we can draw from our findings in this section:

1. At this time it is not possible to provide a reliable and valid comparison of Alberta's experience with that of other Canadian jurisdictions respecting the recruitment and retention of rural physicians.

6.1.3 Recommendations: Effectiveness of RPAP's Initiatives on the Recruitment and Retention of Rural Physicians Compared With Other Jurisdictions

RECOMMENDATION #1:

It is recommended that RPAP undertake a joint study with BC and Saskatchewan to examine the effectiveness of each jurisdiction's recruitment and retention initiatives.

Explanatory Note:

The focus of the study would be the in/out migration of rural physicians. The study should include a classification of different size communities equivalent to the typology used by Dr. Pong—Research Director of the Centre for Rural and Northern Health Research at Laurentian University in Northern Ontario.

In addition, the study should ensure 'contextual' variables are captured, such as financial incentives used in each jurisdiction to attract and retain rural physicians and changes in the 'political' climate that often occur during "fee negotiations", as well as other "environmental" factors.

7.1.1 Findings: Stakeholder Perspective of the Rural Physician Action Plan

RPM personnel interviewed the following key stakeholders and our findings are presented in the next several paragraphs:

- Regional Medical Directors—Aspen, Chinook, David Thompson, Northern Lights, Peace Country and Calgary;
- Alberta Medical Association (3 representatives—including the Past President of the Section of Rural Medicine);
- College of Physicians and Surgeons of Alberta;
- UofA and UofC Faculties of Medicine;
- SAIT Health Sciences;
- UofC Faculty of Nursing;
- STARS;
- Alberta Community Development;
- Alberta Agriculture, Food and Rural Development; and
- Alberta Health and Wellness.

The Regional Medical Directors' Perspective

Most stakeholders reported they have 'informal' rather than 'formal' linkages with RPAP. These informal linkages comprise the specific RPAP programs used by the stakeholders. For example, many of the Regional Medical Directors mentioned the following RPAP initiatives which have helped the Health Authorities recruit and retain physicians by increasing their capacity and confidence to address the health needs of their communities:

- Enrichment Program to enhance the skills of practicing physicians;
- Recruitment Fairs;
- Matching Signing Bonus;
- Recruitment Expenses Reimbursement Program;
- Rural Physician Spousal Network; and
- CME for rural physicians.

Some of the Regional Medical Directors pointed out they also have 'formal' linkages with RPAP. Specifically, these Regional Medical Directors noted that they participate in education/training by providing teaching sites for the Alberta Rural Family Medicine Network, as well as for rural rotations for undergraduates and postgraduates of the Family Medicine Programs at the UofC and UofA.

A few of the Regional Medical Directors noted they have approached RPAP to plan and implement new initiatives in their Regions, such as a CME conference. They noted that RPAP is 'very responsive' to exploring new ideas to assist them with recruiting and retaining physicians.

None of the six Regional Medical Directors we interviewed reported hearing any complaints about RPAP from the rural physicians. And, each of the Regional Medical Directors provided examples of commendations they have received about RPAP from rural physicians, such as the Additional Skills and Enrichment Programs; the Rural On-call Program; the Rural Locum Program; the Matching Signing Bonuses; and arranging for assessments of International Medical Graduates.

Some of the Regional Medical Directors perceive RPAP as a major ‘influencer’ respecting government policy related to rural physician recruitment and retention. They pointed out that, in the past, RPAP has been a vehicle to implement government policy to address physician shortages in rural Alberta.

During our interviews we explored whether RPAP’s mandate should be altered. While most of the Regional Medical Directors don’t see a need to change RPAP’s mandate, many believe RPAP should be preoccupied with recruitment and retention of rural physicians to the ‘small town’ rather than the ‘small city’. One Regional Medical Director pointed out that RPAP has done such a good job in establishing initiatives aimed primarily at Family Practice physicians, it should do the same for ‘specialists’.

The Regional Medical Directors noted that over the last several years the number of medical students choosing Family Medicine as a career has been declining. Others pointed out that in the not too distant future there will be a problem with the supply of ‘GP specialists’—such as FP anaesthetists, GP surgeons, and GP obstetricians. Accordingly, some of the Regional Medical Directors expressed a need for RPAP to take a leadership position with other stakeholders to develop ‘manpower planning processes’ and to continually monitor the factors that influence recruitment and retention of rural physicians, and proactively intervene where possible. They noted this is multifaceted and, while it may not be RPAP’s role to forecast ‘physician manpower needs’, RPAP’s ability to develop appropriate strategies and initiatives can only be enhanced with this type of information.

The following are some of the factors the Regional Medical Directors noted that are having a significant influence on the recruitment and retention of rural physicians:

- increase in the number of female physicians;
- reluctance of more recent graduates to work long hours as they try to achieve a reasonable work/life balance; and
- a preponderance of International Medical Graduates from the Middle East and the Far East, which creates new challenges in their training because of cultural and language differences.

Notwithstanding these concerns, some of the Regional Medical Directors pointed out that RPAP’s Rural On-Call Program²², the Rural Locum Program, the Matching Signing Bonus Program, and the ARFMN have made a substantial improvement in the recruitment and retention of rural physicians.

According to the Regional Medical Directors, RPAP does a reasonably good job in keeping them informed about recruitment and retention issues. They also noted that RPAP’s current level of reporting respecting achievement of its Key Performance Indicators is sufficient.

During our interviews with the Regional Medical Directors we asked if they thought RPAP duplicates services that rightfully belong in the domain of other organizations. Four of the six Regional Medical Directors stated they do perceive that RPAP does not duplicate services offered by other organizations.

Three of the six Regional Medical Directors we interviewed have participated on an RPAP Working Group related to planning new initiatives. These individuals expressed their appreciation in having the opportunity to bring the perspective of their constituents to the discussion.

22. The Rural On-Call Program is now funded through the Trilateral Master Agreement between the Alberta Medical Association, Alberta Health and Wellness, and the Regional Health Authorities, which was signed in 2003.

When asked about the performance of the RPAP Program Manager, all six Regional Medical Directors stated they were 'very satisfied'. They noted that the RPAP Program Manager provides good leadership and is:

- innovative and open to new ideas;
- easy to approach;
- a good communicator and follows-up things to completion.

The Alberta Medical Association's Perspective

RPM personnel interviewed three representatives from the Alberta Medical Association—including the Past President of the Section of Rural Medicine. Two of the three representatives from the AMA identified an underlying concern from their perspective with the Rural Physician Action Plan—namely, it is not helping to attract physicians to small/remote communities. Although these individuals acknowledge that RPAP's educational 'pipeline' may one day increase the supply of rural physicians who choose to practice in small/remote locations, to date the perception is that many of the residents who have completed their residency training through the ARFMN have typically chosen to practice either in a regional centre—such as Lethbridge, Medicine Hat, or Red Deer—or in a large rural community. And, this is happening at a time when, as one individual stated, "30 communities are critically short of doctors."

These two AMA representatives believe RPAP should be doing more to recruit physicians to small/remote communities, particularly in the short term. This would require RPAP to alter its approach and play a 'direct' role in recruiting rural physicians, rather than continuing with its current role of:

- providing organizations such as the Regional Health Authorities and local communities with tools and incentives they can use to facilitate their recruitment and retention efforts; and
- increasing the supply of rural physicians by:
 - ⇒ encouraging high school students, medical students and residents to choose a career in rural medicine
 - ⇒ reimbursing some of the expenses incurred by rural RHAs and newly recruited physicians
 - ⇒ arranging for training and/or assessment of physician to enable individual rural physicians to attain licensure and/or additional privileges

On one hand the perspective of these two AMA representatives is not surprising given the shortage of physicians in small/remote communities in Alberta, coupled with the fact that the educational strategies spearheaded by RPAP have not yet made any appreciable difference to the supply of rural physicians who are willing to locate in small towns. However, on the other hand this perspective is quite surprising when Dr. James Rourke, as representative for the Task Force of the Society of Rural Physicians of Canada stated in a recent article (2005) that, "the Society of Rural Physicians of Canada (SRPC) recognizes the importance of educating physicians for rural practice. Because students with a rural background are the most likely to ultimately choose rural practice as a career, achieving an adequate supply of rural physicians depends in part on ensuring the admission of an adequate number of students of rural origin to medical school."²³ In fact, many of the 'position papers' published by the Society of Rural Physicians of Canada and, the international literature show a high degree of congruence with many of RPAP's initiatives.

23. Rourke, J, Strategies to increase the enrolment of students of rural origin in medical school: recommendations from the Society of Rural Physicians of Canada. CMAJ 2005; 172 (1) 62-65.

These two AMA representatives indicated they need to regain their confidence that the Program Manager will bring the AMA's perspective forward to the RPAP Coordinating Committee respecting issues that are critical to the AMA.

The third AMA representative interviewed by RPM personnel focused the discussion on the major factors that influence recruitment and retention of rural physicians. He noted that 'stage in the life cycle' is often over-looked as a critical recruitment/retention factor. For example, he suggested that when a physician is looking for her/his first 'practice opportunity', there can be a greater emphasis on taking advantage of financial incentives that are offered as part of a 'recruitment package', and less emphasis on non-financial aspects—such as community factors. However, as the family moves through different stages in the life cycle, other factors become more predominant in the 'family's' decision to stay or leave the community. If the physician and his/her spouse grew up in a rural community, they may be in a better position to adapt compared with someone who was raised in an urban environment.

Using the 'stage in the life cycle' as a backdrop, the third AMA representative interviewed by RPM personnel suggested that the Rural Physician Spousal Network has the potential to play an important role in physician recruitment and retention. He noted that the spouse is a significant influencer in location decisions.

This AMA representative also suggested that RPAP should find ways to improve physicians' 'practice life', by encouraging physicians to strike a better work/life balance. During the discussion, he noted that financial incentives to entice physicians to accept specific types of 'work'—such as on-call—can have a negative impact on physician wellness. For example, the Rural On-call initiative enticed more physicians to undertake 'after hours' call. While this benefited patients, it has been somewhat detrimental to physician wellbeing, because now physicians are somewhat burdened by this 'extra work' that they willingly accepted. He thought it would be helpful if RPAP could focus on this issue and increase the awareness among the RHAs and rural physicians of the initiatives of other organizations, such as the AMA—which can help physicians and their families to address issues of work/life balance.

During the interview, this AMA representative also talked about the importance of RPAP establishing a 'partnership' with communities in the area of recruitment, that would go beyond developing tools that the RHAs and local areas could use in their recruitment efforts. Within the context of some of the positive comments noted earlier by Regional Medical Directors and others, and the ongoing community development work RPAP is nurturing, this perspective suggests a lack of awareness of how the RPAP and its consultants actually work with various constituents.

The College of Physicians and Surgeons' Perspective

RPM personnel interviewed the Registrar of the College of Physician and Surgeons of Alberta. RPAP has a unique relationship with the CPSA because in 1996, the RPAP was devolved from Alberta Health, as an "arms-length entity". Although the College of Physicians and Surgeons has been responsible for the administration of RPAP's 'banking' function (i.e., accounts receivable, accounts payable and financial reporting), the RPAP CC remains the oversight body for the RPAP—and the CPSA is represented on the RPAP CC.

This formal linkage between RPAP and the College of Physician and Surgeons of Alberta allows the College to keep its finger on the pulse of the health system. He pointed out that the College ensures 'public safety' through credentialing and licensure of physicians. The CPSA representative on the RPAP CC helps the College stay informed as to whether there is a sufficient number of rural physicians with the appropriate skills and training to meet the needs of the population. And, this information is an indicator of the success of the College's credentialing processes.

The Registrar noted that RPAP also benefits from this linkage with the College of Physicians and Surgeons. He pointed out that the College has worked cooperatively with RPAP to design procedures for conducting assessments for those rural physicians who acquire additional skills and are seeking additional privileges.

During the interview the Registrar indicated he has heard many commendations about RPAP and no complaints. He noted that organizations such as the AMA and the Northern Alberta Development Council appreciate RPAP's efforts in supporting rural physicians.

The CPSA perceives RPAP as a major influencer respecting government policy related to rural physician recruitment and retention. The Registrar pointed out that RPAP provides a high degree of leadership in working with government and other key stakeholders to address the shortage of rural physicians. He stated that RPAP always works within the context of the College's concern for public safety and quality care.

During the interview the Registrar pointed out there are some factors that influence recruitment and retention of rural physicians which are outside RPAP's purview, including:

- competition between communities in the same RHA for physicians;
- the absence of built-in incentives in the fee schedule to incent physicians to practice in rural areas; and
- creation of incentives specifically for rural physicians without creating a perception of inequality among members of the physician community.

The Registrar noted there is no other organization that focuses exclusively on rural issues. This has helped RPAP to carve out a niche for itself and focus its attention on findings ways to address the key variables that affect rural physician recruitment and retention—such as the 'supports for the spouse and family', and establishing a process for welcoming new physicians and their families to rural Alberta.

The Registrar reported he is 'very satisfied' with the performance of the RPAP Program Manager. He noted that the Program Manager is:

- a good ambassador for RPAP;
- engaging;
- articulate;
- bright; and
- easy to work with.

During the interview the Registrar noted that the health system is changing, and the roles of physicians and other health care providers are also changing. This is creating a different context for RPAP. Accordingly, he suggested that RPAP should be thinking about how it should be positioned in the longer term—which means looking beyond its current accomplishments and thinking about how it can support the objectives of other key stakeholders in meeting the health needs of rural Albertans.

The Perspective of the Faculties of Medicine (UofC and UofA)

Representatives of both Faculties of Medicine stressed that there is a symbiotic relationship between themselves and RPAP. The universities provide the educational training for medical students and residents and, RPAP assists with funding to carry out their education mandate. For example, RPAP assists with the costs of 'faculty development' activities for rural preceptors to ensure they have the appropriate skills to effectively teach students and residents during their rural rotations. They also noted that RPAP arranges for housing for residents during their rural rotations. In addition, RPAP provides significant financial and other support to the residents in the Alberta Rural Family Medicine Network.

Moreover, each of the two Faculties has a representative on the RPAP Family Medical Network Education Subcommittee to assist in guiding the further development of ARFMN. Furthermore, RPAP helps to maintain a focus on 'rural medical education' which prompts the universities to consider new and innovative ideas, such as the creation of the new position of Associate Rural Deans. In addition, the Department Head of the University of Calgary Department of Family Medicine also mentioned that RPAP supports its 'outreach research activities' to rural physicians.

The Faculty representatives interviewed explained that there are several benefits which accrue to RPAP through this symbiotic relationship, such as:

- increasing the supply of highly skilled rural physicians;
- creation of highly talented preceptors which adds to their self-esteem and is a factor involved in their decision to continue to stay in rural practice; and
- development of 'best practice' based on research undertaken by the universities.

The representatives from both Faculties mentioned the extensive increase in the number of RPAP 'educational' initiatives aimed at increasing the supply of rural physicians by influencing students to choose a career in rural medicine. They noted that as the medical school and residency programs have expanded, there has been an ever increasing need for more 'teaching sites'. This could result in a problem in delivering high quality rotation experiences in the future. It could also create an additional burden on the existing complement of rural preceptors.

One Faculty representative believes that RPAP should broaden its view beyond 'physicians' and consider focusing on 'rural health', which involves a wide variety of health care professionals. This perspective comes from a concern that the 'role' of physicians in health care delivery is on the cusp of change (e.g., rural physicians working in teams with other health care professionals) and, therefore, RPAP should be proactive rather than reactive.

One representative believes that RPAP should be doing 'direct' recruiting of rural physicians. This individual suggested that RPAP should establish a 'recruiting division'.

One of the two Faculty representatives believes RPAP needs to pay more attention to training FP anaesthetists, GP surgeons, and GP obstetricians. This individual noted that FP anaesthetists are critical to maintaining a viable rural practice in many communities.

Both representatives noted that although there has been a decline in the last decade in the number of medical students choosing family medicine, their performance in the 2005 CaRMS Match has been significantly better than in 2003. This occurred as a result of increased exposure of medical students to the area of 'family medicine'.

Although the two Faculties are not represented on the RPAP CC, they have participated on various RPAP Working Groups related to planning new initiatives. While these Working Groups provide opportunities for the universities to contribute their expertise in shaping RPAP initiatives, this can only occur if the Chair of these Working Groups and/or the RPAP Program Manager delegates specific tasks to 'teams' of committee members. Under these circumstances, members of a Working Group have the greatest opportunity to apply their expertise to the issues at hand, build a consensus, and accept ownership over the finished product.

One university indicated it is 'very satisfied' with the performance of the RPAP Program Manager, while the other stated it is 'somewhat satisfied' with the Program Manager's performance.

The Perspective of Other Stakeholders

RPM personnel interviewed representatives from the following stakeholders, and our findings are presented in the next several paragraphs:

- SAIT Health Sciences;
- UofC Faculty of Nursing;
- STARS;
- Alberta Community Development; and
- Alberta Agriculture, Food and Rural Development

Each of these stakeholders noted that part of their mandate includes a 'rural focus'. Some of these organizations explained that the connection with RPAP "broadens our understanding of issues facing rural communities", while others noted RPAP has agreed to collaborate on some initiatives, such as the GEMS initiative (General Emergency Medical Skills).

This linkage has helped RPAP in shaping some of its initiatives. For example, advice provided by Alberta Community Development helped RPAP in developing its Community Resource Guide.

These stakeholders had significant praise for the RPAP staff. For example, one of the stakeholders stated that RPAP staff regularly come out to the rural communities. This has the effect of developing trust between the community and RPAP personnel.

All of these stakeholders indicated that RPAP does not duplicate services that rightfully belong in the domain of other organizations. In fact, they noted that RPAP is providing a 'unique' service because it takes a 'provincial' rather than a 'regional' perspective.

The Perspective of Alberta Health and Wellness

After RPAP was devolved from Alberta Health in 1996, the Ministry continued to provide RPAP with its annual funding. The linkage with Alberta Health and Wellness has provided RPAP with important 'intelligence' about how certain concepts/ideas/plans respecting rural physician recruitment and retention will be perceived by the government. Alberta Health and Wellness benefits because RPAP is proactive in working on rural health issues.

Alberta Health and Wellness has used RPAP to assist in planning and implementing new initiatives such as RPAP's new bursary program that compliments its existing Rural Medical School Award Program. The new bursaries will cover 100 per cent of a student's medical school tuition in return for a five-year commitment to practice in rural Alberta. When Alberta Health and Wellness has approached RPAP to consider new initiatives, it has found RPAP to be 'very responsive'.

Alberta Health and Wellness considers RPAP to be a major influence periodically respecting government policy related to rural physician recruitment and retention. When an opportunity for change presents itself, Alberta Health and Wellness is able to rely on RPAP to assist with the logistics of implementation. This provides government with a high degree of confidence that the concept will be supported and welcomed by those involved in rural medicine. This occurred with the establishment of the ARFMN, the Rural On-call Program, and the new RPAP bursary program.

Alberta Health and Wellness is 'very satisfied' with the performance of the RPAP Program Manager. The Alberta Health and Wellness representative we interviewed indicated that the RPAP Program Manager is:

- constructive;
- willing to take other's perspective;
- quite knowledgeable about the health system; and
- hard working.

7.1.2 Conclusions: Stakeholder Perspective of the Rural Physician Action Plan

There are four key conclusions we can draw from our findings in this section:

1. RPAP maintains a positive working relationship with most of its key stakeholders. It is open to new ideas and supportive of initiatives brought forth by other organizations that will enhance recruitment and retention of health care professionals. The RPAP Program Manager is considered by most stakeholders to be a great ambassador for the organization, who is hard working, thoughtful and creative.
2. Stakeholders perceive that over the years RPAP has developed some important initiatives related to rural physician recruitment and retention.
3. Some of RPAP's key stakeholders believe it is time for RPAP to become more heavily involved in 'direct' recruitment activities, leading to an increase in the supply of physicians in small/remote communities.
4. Some of the key stakeholders believe RPAP needs to change. They are of the opinion that changes in the health care delivery system, a greater emphasis on rural development, as well as changing roles of physicians and other health care professionals, require RPAP to consider thinking about how it should be positioned in the longer term—which means looking beyond its current accomplishments and thinking about how it can support the objectives of other key stakeholders in meeting the health needs of rural Albertans.

RECOMMENDATION #1:

It is recommended that RPAP convene a Round Table Discussion to examine its future direction and how it can support the objectives of other key stakeholders in meeting the health needs of rural Albertans.

Explanatory Note:

To be successful, the Round Table Discussion should include the use of an external facilitator who:

- is knowledgeable about the health system and the mandates of most/all of the invited organizations;
- has a demonstrated understanding of the complex interplay of the various factors involved in rural physician recruitment and retention;
- has excellent facilitation skills and demonstrated ability in being able to prepare a report which captures the content of the discussion;
- has a reputation for being able to maintain his/her objectivity and neutrality during the facilitation; and
- is acceptable to most of the invited organizations.

The Round Table Discussion should include an examination of the objectives of the key stakeholders and a determination of the ways RPAP can support their objectives related to recruitment and retention of rural physicians and other health care providers. The Round Table Discussion should include organizations from inside and outside the medical profession. That is, it should not be restricted solely to rural physicians, CPSA, the AMA, the RHAs, the two universities (UofC and UofA), and Alberta Health and Wellness. The Round Table Discussion could also include 'Alberta Community Development', 'Alberta Agriculture, Food and Rural Development, and the 'Northern Alberta Development Council'. However, the Round Table Discussion needs to focus on establishing priorities for rural medicine.

8.1.1 Findings: RPAP's Governance

As part of the evaluation, RPM personnel interviewed five of the seven members of the RPAP Coordinating Committee. During the interview we asked questions related to RPAP's governance structure. Our findings are presented in the next several paragraphs.

All five RPAP CC members stated that RPAP uses a 'policy governance' model. That is, the RPAP CC restricts itself to policy issues, and delegates implementation to staff. The RPAP CC members reported that policy issues normally include strategic planning, defining expected results and priorities, and placing limitations on the means to be used to achieve those results.

The Program Manager is RPAP's single link to the RPAP staff—i.e., the Rural Physician Consultants, the RPAP Skills Brokers, the Communications Consultant, the RPAP Research Consultant, and the administrative staff. With the support of his staff, the Program Manager is responsible for the implementation of policies and for the ongoing operation of RPAP. He is authorized to establish subsidiary policies, make decisions, take actions and develop activities within the limits set by the RPAP CC.

As the most senior contractor of RPAP, the Program Manager is often called upon to represent the organization and speak on RPAP's behalf. He does this with the support of the RPAP CC.

All five of the RPAP CC members we interviewed reported they are committed to maintaining the current governance structure. One of the committee members, however, believes the RPAP CC could be more effective in providing 'oversight' by doing a better job in linking the following key variables together—objectives of specific initiatives, a budget for each initiative, and the staff time required to achieve the objectives. This individual perceives that this type of information would help the RPAP Coordinating Committee to:

- make decisions about which programs to support; and
- determine if staff are performing effectively.

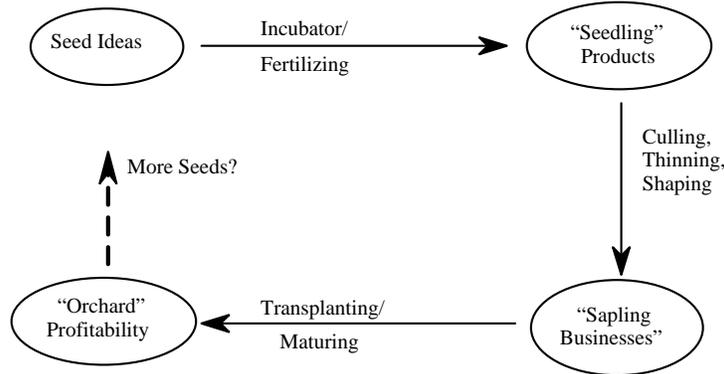
While this proposition may have some merit, it also creates the potential for the RPAP CC to become embroiled in operational issues and stifle innovation. It is our understanding that having thoroughly discussed the advantages and disadvantages of this concept, the RPAP CC chose not to approve this suggested approach, but decided upon a somewhat different approach.

Although this issue has not been resolved to everyone's satisfaction, the RPAP CC, in 2004, began an annual Fall review of the budget prior to consideration of the new fiscal year allocation. This review consisted of an explanation/discussion of each expenditure, its objectives and how it fits within the RPAP Vision, Mission and strategic direction. If in the future the RPAP CC considers changing its approach to 'financial oversight', it should keep in mind that board oversight of staff discretion can be effectively achieved by creating a workable set of policies that provide some limits to executive latitude, rather than trying to control many details and intrude in the operations of the organization.

Stakeholders have noted that the RPAP Coordinating Committee’s policy governance model, and its lack of intrusion in operations, has permitted the organization to be highly innovative. It is our opinion that RPAP’s willingness to experiment has followed the ‘horticultural model’ outlined by Lockerd, Manager of Corporate Strategic Planning at Texas Instruments in an article entitled, “Can Innovation Flourish Alongside Productivity Measurement?” Lockerd discusses an approach to innovation he calls “innovation horticulture”.

EXHIBIT 33

INNOVATION HORTICULTURE



Lockerd states that in the early stages of innovation—the incubation and germination stages—ideas are everywhere. He notes that since more people have ideas, and more of those ideas are potentially good than one will ever realize, it is important to have a method of capturing those ideas. He states, “basically you have to set aside a kind of nursery function and some fertilizer for that as a start-up. Otherwise you get the normal forest effect, in which only evolutionary products develop—that is, all of the resources will go into new models of a current product, while very little or none goes into totally different things.”

The second stage in Lockerd’s ‘horticulture model’ is ‘culling, thinning, and shaping’. He states, “you do not keep all the potential innovations going very long; instead, you do some reasonable early ‘thinning’”—the purpose of which is to identify who wants this innovation and the benefits likely to accrue to the individual/organization.

The third stage of Lockerd’s ‘horticulture model’ involves ‘transplanting’ innovations from the nursery—that is, full implementation. He points out there is usually substantial work involved in getting everything ready to implement an innovation.

Lastly, Lockerd states, “patience is very important. It takes more than a season or two to get the roots down in many cases.” He cautions that one might not immediately see the expected benefits of the innovation and, therefore, it is important to be patient.

8.1.2 Conclusions: RPAP's Governance

There are two key conclusions we can draw from our findings in this section:

1. RPAP's governance model is working well and has the support of the RPAP Coordinating Committee.
2. Establishing too much oversight could stifle RPAP's ability to be innovative—a trait which is highly regarded by many of RPAP's key stakeholders.

8.1.3 Recommendations: RPAP's Governance

RECOMMENDATION #1:

It is recommended that RPAP CC continue with its regime of policy governance and its current process of establishing policy direction and executive limitations including: annual Program Manager 360° review, RPAP CC self-evaluation, approval of the three-year business plan and its annual review, the Fall budget review held prior to consideration of the new budget allocation, and the approval of the annual operational objectives.

**UTILIZATION OF RPAP'S ASSETS TO
ADDRESS CRITICAL CHALLENGES**

9.0 UTILIZATION OF RPAP'S ASSETS TO ADDRESS CRITICAL CHALLENGES

This section of the evaluation report outlines RPAP's key assets and how they are/can be utilized to effectively address critical challenges. These consist of the RPAP Coordinating Committee, the Program Manager, and the RPAP staff/consultants.

9.1 CRITICAL CHALLENGES FACING THE RURAL PHYSICIAN ACTION PLAN

RPAP's most recent Business Plan (2005/06 to 2007/08) includes an 'environmental scan' which identified the following critical challenges facing the organization:

- The RPAP must continually assess access to timely medical care (for example rural radiology services) and changes in the number and skill sets of physicians. For example the cohort of FP-anaesthetists, GP-surgeons and GP-obstetricians is aging and not being replenished fast enough nor with the same skill set.
- Providing physicians in training with the right skills and a sense of competence and confidence to choose rural practice as a desired opportunity and to provide practicing rural physicians with the ability to easily obtain additional skills that will improve the standard of care in their community.
- Maximizing the opportunities available for effective rural medical education and rural physician retention and leveraging the extensive use of local community educational resources. In so doing the RPAP must continue to cultivate additional rural preceptors especially specialty preceptors and better coordinate learners and preceptors to prevent preceptor burnout.
- The RPAP implemented the Alberta Rural Family Medicine Network (ARFMN) starting in 2000-2001 as part of the previous three-year business plan. An additional 10 PGY positions per year were added beginning in 2005. And beginning in 2004, an expansion in the number of learners taking rural rotations during UGME and PGME specialty blocks occurred. While this activity is desirable and part of the original goals of the RPAP, the RPAP must continue to take a leadership role in guiding, coordinating and evaluating the ARFMN and the Rural Rotations Program in order to maximize the positive learning experience afforded learners and to mitigate preceptor burnout.
- The RPAP has strived to meet the need for innovative programs to support the rural physician and family and attempt to reduce the personal and family isolation that sometimes occurs with rural living. This is critical if rural physicians and families are to be retained and integrated into their communities.
- Supporting local initiatives and developing creative programs that address innovative ideas for rural physician recruitment retention.
- Promoting rural medicine as a viable professional career amongst rural high school students and junior medical students.

Why are these critical challenges for RPAP? The answer rests, in part, through the regular environmental scanning the RPAP performs and is consistent with findings from the 2004 National Physician Survey collaboratively undertaken by the College of Family Physicians of Canada (CFPC), the Canadian Medical Association (CMA), and the Royal College of Physicians and Surgeons of Canada (RCPSC).

Results of the 2004 National Physician Survey confirmed that many Albertans are experiencing problems obtaining access to physicians. The data show that 51% of Alberta Family Practitioners either limit the number of new patients they see or do not take new patients at all—34% and 17% respectively.

Moreover, the survey data indicate that Alberta's Family Practitioners plan to make changes to their practices by 2006, which will further reduce patient access to medical services. For example:

- 22% plan to reduce weekly work hours (excluding on-call);
- 14% intend to reduce their on-call hours;
- 9% plan to reduce their scope of practice;
- 9% intend to take a temporary leave of absence; and
- 4% plan to move from a rural/remote to an urban/suburban practice setting.

In addition to these startling statistics, the National Physician Survey found that only 20% of Alberta's Family Practitioners are 'satisfied' with the ability to find locum coverage. This acts as a barrier for some Family Practitioners who want to take time away from their practice. Findings from the survey also indicate that 28% of Alberta Family Practitioners reported they were 'dissatisfied' with the balance between personal and professional commitments, while another 15% responded that they are 'neither satisfied nor dissatisfied' with their work/life balance.

9.1.1 Findings: Utilization of the RPAP Coordinating Committee To Address Critical Challenges

The RPAP Coordinating Committee is an asset that can be used to address some of the critical challenges related to rural physician recruitment and retention. The RPAP CC is the governance body for the organization. This Committee has been responsible to the Alberta Minister of Health and Wellness for providing policy advice on issues related to the recruitment and retention of rural physicians, including:

- establishment of provincial goals, objectives and strategies;
- introduction of new programs;
- development of policy, goals, objectives and performance criteria for each RPAP initiative;
- evaluation of the RPAP and RPAP initiatives on a regular basis;
- recommendations to the Minister of Health and Wellness regarding the creation of major new programs or significant modifications to existing programs to enhance rural physician recruitment and retention;
- advice to the Minister of Health and Wellness on matters related to the efficient and effective administration of programs pertaining to rural physician recruitment and retention; and
- allocation of the RPAP budget.

The RPAP CC is comprised of a variety of stakeholders with an interest in the recruitment and retention of rural physicians in Alberta. These stakeholders work together in a cooperative and collaborative manner to try to address the underlying issues of rural physician recruitment and retention.

The seven members of the RPAP CC represent the following five organizations:

- Regional Health Authorities (Chair, plus 1 member);
- Alberta Medical Association Section of Rural Medicine (2 members);
- Alberta Medical Association (1 member);
- College of Physicians and Surgeons of Alberta (1 member); and
- Alberta Health and Wellness (1 member).

During our interviews with five of the seven members of the RPAP Coordinating Committee, they indicated the role of the RPAP CC is to set direction and associated policies that address the critical challenges related to rural physician recruitment and retention. They pointed out that each RPAP CC member represents various constituencies which helps the RPAP CC determine if:

- RPAP's initiatives need fine tuning;
- there are specific communities which could take advantage of RPAP's assistance; and
- new initiatives need to be considered to address emerging issues.

Committee members reported that this foresight is enhanced by the ongoing work of the Program Manager and the RPAP staff/consultants with various 'partners'—such as UofC and UofA Faculties of Medicine, rural physicians/spouses, rural communities, a variety of government departments, as well as the organizations represented by the RPAP CC. This provides important information/insight to the Program Manager, who is then well positioned: (a) to respond to RPAP CC suggestions for new initiatives; and (b) to bring forward emerging issues that require discussion/decision by the RPAP Coordinating Committee. Some Committee members believe that more needs to be done in terms of connecting with other organizations, such as the Alberta College of Family Physicians.

During our interviews, the RPAP CC members pointed out that the Program Manager becomes the conduit for passing information back and forth between the Coordinating Committee and, the RPAP staff/consultants and RPAP's constituents. This process increases the RPAP CC's ability to develop effective responses to emerging issues and the critical challenges related to rural physician recruitment and retention, or to question the Program Manager about the usefulness of some of RPAP's current initiatives.

The RPAP CC has five regularly scheduled meetings during a year, which take place in:

- March to consider the annual budget allocation, review the business plan and the annual UofC In-service;
- April for the annual organizational meeting, UofA In-service and Awards selection;
- June for the RLP Steering Committee In-service;
- October for the annual budget review, approval of the annual reports, and Rural Medical School Award & Bursary selection; and
- December for the Program Manager's performance review, RPAP CC self-evaluation, business plan review, approval of the annual operational objective and review of the KPI.

However, the Committee has met more frequently to address specific issues. The Committee relies on receiving information from the Program Manager on a timely basis including his written reports at each meeting and the bi-monthly e-mail synopsis of major activities. In addition, the RPAP CC Chair and the Program Manager are in contact weekly. Most of the Committee members noted this occurs most often.

As noted earlier in this evaluation report, some stakeholders have expressed a concern that RPAP is not focused enough on recruiting physicians to small/remote communities—and this perspective is shared by some RPAP CC members. Other members of the RPAP CC pointed out that physicians in the Regional Centres provide significant support to the ARFMN and the RPAP rural rotations program and, therefore, meeting the physician resource needs of these communities is also part of RPAP's business.

Most of the RPAP CC believes RPAP is a major influencer respecting government policy related to rural physician recruitment and retention. They pointed out that the establishment of the ARFMN, and the Alberta Cabinet's approval of 10 new bursaries under RPAP's Rural Medical School Award Program, occurred because of the ground work/lobbying undertaken by RPAP.

Although the RPAP CC does some strategic planning, most members believe this should be strengthened. This could be accomplished by establishing a separate 'strategic planning retreat'

rather than trying to undertake this as part of a regularly scheduled RPAP CC meeting, and by using an external facilitator.

9.1.2 Conclusions: Utilization of the RPAP Coordinating Committee To Address Critical Challenges

There are five key conclusions we can draw from our findings in this section:

1. The RPAP Coordinating Committee is reasonably well positioned to address the identified critical challenges facing the organization respecting rural physician recruitment and retention.
2. Utilization of the Program Manager as a conduit for passing information back and forth between the Coordinating Committee and, the RPAP staff/consultants and RPAP's constituents enhances the RPAP CC's ability to develop effective responses to emerging issues, and to influence government policy.
3. One of the key strengths of RPAP is its collaboration/partnerships with a myriad of organizations. The RPAP CC should determine if there are other organizations with which RPAP should be connected.
4. The RPAP CC's approach to policy governance and its current process of establishing policy direction and executive limitations—including annual Program Manager 360° review, RPAP CC self-evaluation, approval of the three-year business plan and its annual review, the Fall budget review held prior to consideration of the new budget allocation, and the approval of the annual operational objectives—should assist the Committee in ensuring it is meeting the critical challenges it faces respecting rural physician recruitment and retention.
5. The RPAP CC should strengthen its strategic planning process.

9.1.3 Recommendations: Utilization of the RPAP Coordinating Committee To Address Critical Challenges

RECOMMENDATION #1:

It is recommended that the RPAP CC strengthen its strategic planning process by having a ‘strategic planning retreat’, using an external resource to facilitate the meeting, and reviewing relevant materials prepared by the Program Manager in advance of the retreat.

Explanatory Note:

The external facilitator should have the following qualifications:

- substantial knowledge about the health system and RPAP’s mandate and initiatives;
- a demonstrated understanding of the complex interplay of the various factors involved in rural physician recruitment and retention;
- excellent facilitation skills and demonstrated ability in being able to prepare a report which captures the content of the discussion; and
- a reputation for being able to maintain his/her objectivity and neutrality during the facilitation.

9.2.1 Findings: Utilization of the RPAP Program Manager and Staff/Consultants To Address Critical Challenges

The RPAP staff/consultants are independent contractors all of whom but the Program Manager are part time. The RPAP staff/consultants are assets that can be used to address some of the critical challenges related to rural physician recruitment and retention. The RPAP team consists of the following individuals and their work is complemented by three administrative staff and members the Alberta Rural Family Medicine Network (ARFMN) Team:

- Program Manager;
- RPAP Skills Brokers for Northern and Southern Alberta;
- Rural Physician Consultants for Northern and Southern Alberta;
- Research Consultant;
- Medical Students' Initiatives Coordinator; and
- Communications Consultant.

RPM personnel interviewed each member of the RPAP team and attended one of the team meetings. The RPAP team meets monthly for approximately four to five hours and communicate with one another, on an as need basis, in between meetings. Approximately 60% of the monthly meeting is spent 'sharing information', 30% on strategic/tactical planning, and 10% respecting decision making/developing recommendations to take to the RPAP CC.

The monthly team meeting provides an opportunity for the team members to learn about each other's roles. This facilitates cross-referrals and the ability to support each other's work related to emergent issues which require follow-up.

RPAP Skills Brokers

The key role of the two RPAP Skills Brokers is to arrange for training and/or assessment of physicians, which enables individual physicians to attain licensure and/or additional privileges. This adds to the supply of rural physicians.

Rural Physician Consultants

The two Rural Physician Consultants perform the following roles:

- connecting face-to-face and through phone/email with rural physicians to identify their practice needs, and any issues related to settling into the community which require resolution;
- facilitating the mobilization of other RPAP resources by relaying needs of rural physicians to other RPAP team members as required, to ensure that the appropriate RPAP support is provided quickly;
- developing partnerships and using these partnerships to pilot new initiatives to address rural physician recruitment and retention issues; and
- increasing the capacity of other organizations to undertake 'direct' recruitment of rural physicians.

RPM personnel reviewed the Monthly Reports submitted by RPAP staff/consultants for the period 2001/02 to 2004/05 in order to gain an understanding of some of the specific initiatives undertaken by the Rural Physician Consultants. During this time period there has been a total of four Rural Physicians Consultants (a maximum of two working at any one time).

When we reviewed the Monthly Reports submitted by RPAP staff/consultants, we classified the work of the Rural Physician Consultants into the following four categories:

- retention initiatives/activities undertaken directly by the Rural Physician Consultants (such as community site visits);
- activities undertaken by the Rural Physician Consultants which enabled other organizations to take action related to retention of rural physicians;
- 'direct' recruitment activities undertaken by the Rural Physician Consultants; and
- activities undertaken by the Rural Physician Consultants that influence students to select 'rural medicine' as a career choice, or which enabled other organizations to take action related to recruitment of rural physicians.

Sometimes the Monthly Reports lacked a detailed description of the activities undertaken by the Rural Physician Consultants, and this reduced our level of accuracy in classifying their work. Nonetheless, Exhibit 34 indicates that the Rural Physician Consultants have spent their time primarily undertaking 'direct' retention activities and 'enabling' recruitment activities.

EXHIBIT 34

ACTIVITIES OF THE RURAL PHYSICIAN CONSULTANTS: 2001/02 AND 2004/05

	Rural Physician Consultants (Northern and Southern Alberta)
'Direct' Retention Activities	94 (66%)
Enabling Recruitment Activities	41 (29%)
Enabling Retention Activities	7 (5%)
'Direct' Recruitment Activities	0 (0%)
Total	142 (100%)

The following are some examples of 'direct' retention activities undertaken by the Rural Physician Consultants:

- As an added incentive to encourage physicians to remain in rural Alberta, RPAP, the former RHA #5 and the David Thompson Health Region partnered to introduce a pilot program that enabled physicians to take a sabbatical leave of up to four months. It was aimed at preventing burnout, promoting health and well-being and enabling additional skills training.
- The Rural Physician Consultant North completed site visits to address concerns by the physicians and their respective communities.

The following are some examples of 'enabling' recruitment activities undertaken by the Rural Physician Consultants:

- The Rural Physician Consultant South and the RPAP Program Manager made a presentation to 20 individuals in Trochu respecting the Community Resource Guide—which is a tool developed to help RHAs, rural communities, and physicians work together to design and implement recruitment and retention initiatives.
- The Rural Physician Consultant South was contacted by a rural physician in Coronation who requested that the Rural Physician Consultant follow-up with a third year B.Sc. student who seemed interested in a career in rural medicine. Follow-up activities were undertaken by the RPAP Consultant.
- The RPAP Coordinating Committee approved a community grant application for Tofield. The Rural Physician Consultant North worked with the community to identify how best to utilize the grant funding for physician recruitment.
- The Rural Physician Consultant North met with the Executive Director of the Peace Region Economic Development Authority, an alderwoman from the City of Grande Prairie and a business owner who were spearheading international recruitment in Europe. They wanted to work more closely with RPAP and include 'physician recruitment needs' in their international efforts.

Research Consultant

The RPAP Research Consultant has several roles, including:

- supporting the internal evaluation and research needs of the RPAP including compiling the annual Key Performance Indicators;
- supporting the research and evaluation needs of the residents and of the nodes of the ARFMN (i.e. Rural Alberta North and Rural Alberta South); and
- assisting rural physicians interested in conducting research to find the resources available to do so, with particular emphasis on the RPAP's SEARCH program alumni.

Medical Students' Initiatives Coordinator

The RPAP Medical Students' Initiatives Coordinator is responsible for supporting the Rural Medicine Interest Groups at the UofC and UofA, and through them to organize the following activities as a means to expose these individuals to rural practice and influence them in choosing rural medicine as a career:

- Skills Days;
- Summer student experience program;
- rural hospital tour weekends; and
- opportunities for medical students to shadow rural preceptors for a weekend.

RPAP Communications Consultant

The RPAP Communications Consultant is responsible for:

- developing and implementing a 'strategic communications and marketing plan';
- facilitating the annual Award of Distinction Program which includes all the related communication and marketing, web site updates, and working with a video company to shoot the video;

- facilitating the communications elements of the work of other RPAP team members;
- coordinating efforts of more than 40 organizations across the province respecting the planning and implementation of annual Rural Health Week.

RPAP Program Manager

The RPAP Program Manager has several responsibilities, including:

- articulating in real terms the RPAP Vision and Mission;
- executing policy developed by the RPAP CC;
- establishing and maintaining good relationships with RPAP partners;
- undertaking ongoing Environmental Scanning and presenting program initiatives to the RPAP CC; and
- managing the day-to-day operations of RPAP.

During our interviews with the members of the RPAP team, they pointed out that the Program Manager becomes the conduit for passing information among the team. This process increases the team's ability to develop effective responses to emerging issues and the critical challenges related to rural physician recruitment and retention.

8.2.2 Conclusions: Utilization of the RPAP Program Manager and Staff/Consultants To Address Critical Challenges

There are five key conclusions we can draw from our findings in this section:

1. The RPAP team of staff/consultants (including the Program Manager) is well positioned to address the identified critical challenges facing the organization respecting rural physician recruitment and retention.
2. The monthly team meetings are essential in building an understanding of each other's roles. This facilitates cross-referrals and the ability to support each other's work related to emergent issues which require follow-up.
3. The Rural Physician Consultants are primarily involved in 'direct' retention activities and 'enabling' recruitment activities. None of their work involves 'direct' recruitment of rural physicians.
4. The work of the RPAP Skills Brokers in arranging for training and/or assessment of physicians adds to the supply of rural physicians.
5. The RPAP Program Manager plays a pivotal role in ensuring the RPAP team members have the necessary information and direction to meet the needs of RPAP's constituents while executing the policy developed by the RPAP CC.

9.2.3 Recommendations: Utilization of the RPAP Program Manager and Staff/Consultants To Address Critical Challenges

There are no recommended changes.

**COMPARISON OF THE ALBERTA RURAL
PHYSICIAN ACTION PLAN WITH
INTERNATIONAL EXPERIENCE**

10.0 COMPARISON OF RPAP WITH INTERNATIONAL EXPERIENCE

This section of the evaluation report briefly compares the Alberta Rural Physician Action Plan with rural physician recruitment programs/initiatives launched by other countries. We have drawn on the experience of the United States, Australia, and the United Kingdom.

10.1.1 Findings: Comparison of RPAP With the Experience of Other Countries

RPM personnel searched the internet for equivalent programs to RPAP. We focused our search on the experience of the United States (US), Australia, and the United Kingdom (UK). We found similarities between some of RPAP's and those offered in the United States and Australia.

Experience in the United States

In the United States, the Physician Shortage Area Program (PSAP) was established in 1974 to address Pennsylvania's rural physician shortage. This is an admissions and educational program designed to increase the supply and retention of family physicians in rural areas and small towns by recruiting and educating medical students who:

- Grew up in a rural area or small town, or spent a substantial portion of their life in a similar area; and
- Intend to practice the specialty of Family Medicine in a rural area or small town.

Since that time, the PSAP has been highly successful in increasing the number of rural family physicians. Outcomes of the PSAP, published in the *New England Journal of Medicine* and the *Journal of the American Medical Association (JAMA)*, have shown that PSAP graduates:

- are more than 8 times as likely as their peers to become rural family physicians;
- have a retention rate of 87% after 5-10 years in practice; and
- account for 21% of family physicians practicing in rural Pennsylvania who graduated from one of the state's 7 medical schools, even though they represent only 1% of graduates from those schools.

Some of RPAP's initiatives emulate the programs developed by WWAMI—an enduring partnership between the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana, and Idaho. For example, WWAMI has launched a High School Program consisting of a 6-week summer enrichment experience. The program's goal is to foster, affirm, and encourage the interest of high school students living in medically underserved areas in the medical profession by allowing them to explore medical careers and to get a valuable introduction to college life.

Similarly, WWAMI offers a Rural/Underserved Observation Experience to medical students. Interested students shadow, for one day, a physician who works in a rural and/or underserved setting. Moreover, between their first and second years, the Rural/Underserved Observation Experience Program offers students preceptorships with practicing physicians in small towns across the WWAMI states and among the urban medically underserved.

WWAMI also offers a Medical Student Research Training Program which provides funded opportunities for students to participate in a full-time, 10-week research project under the supervision of a University of Washington faculty member. Projects include basic science and clinical research as well as health services utilization studies. Students may do their research with faculty members located at the University of Washington as well as at the WWAMI sites.

Experience in Australia

In Australia, the Rural and Remote General Practice Program (RRGPP) is a 1998-99 Australian Government initiative created from the pre-existing General Practice Rural Incentive Program plus additional funds from the 1998-99 budget allocated under the New Directions in General Practice measure.

Under the Rural and Remote General Practice Program, Rural Workforce Agencies in each State and the Northern Territory are funded to provide a range of activities and support to improve the attraction, recruitment and retention of GPs to rural and remote areas. This includes helping communities to recruit GPs, finding appropriate placements for doctors who want to relocate to rural Australia, assisting with the costs of relocation, supporting their families with fitting into a new community and helping doctors to access the necessary infrastructure, support and training. Rural Workforce Agencies are also the central point of contact for GPs and other health professionals interested in practising in rural and remote areas.

Funding is also provided to the Australian Rural and Remote Workforce Agencies Group (ARRWAG), the national coordinating body, which provides support for Rural Workforce Agencies (RWAs). This includes national advocacy and representation, effective coordination and administration, and management of national data relating to rural workforce activities. ARRWAG also contributes to Australian Government rural and remote health program and policy development.

New South Wales has established a 'Rural Medical Family Network', which aims to aid integration of the physician and his/her family within the community by reducing isolation and creating social networks. Services include:

- supporting medical families in rural/remote medical practice;
- creating a 'friendship network' to lessen feelings of loneliness and isolation experienced by some families;
- providing comprehensive family programs at CPD weekends/medical conferences that encourage the whole family to attend;
- offering assistance to medical students interested in rural living; and
- running initiatives such as 'meet and greet' sessions, crisis assistance and spouse retraining/education grants.

Experience in the United Kingdom

The United Kingdom is not as advanced as Australia or the United States in addressing rural physician recruitment and retention. For example, the British Medical Association (BMA) released a report this year (2005) entitled, Healthcare in a Rural Setting, which contains several recommended strategies to address the major factors related to rural physician recruitment and retention, including:

1. A broad range of strategies should be implemented to promote medicine to potential students from a rural background and encourage them to apply to medical school. Programs for rural secondary school students should be run to promote medicine as a career. Medical schools in partnership with the local authority should implement these as widely as possible.
2. It is desirable that all medical students have the opportunity to choose a rural placement. The opportunity should be seen as a positive contribution to a student's medical development. Placing students in a rural area could promote working in a rural area as a positive career choice.
3. Postgraduate training programs should use the opportunities provided in rural primary and secondary care to teach generalist skills to health care professionals (including surgeons) during their basic training.
4. Continuing professional development should be flexible and responsive to the range of needs found in rural/remote medical practice and tailored to the educational needs identified by the individual.
5. Schemes to support healthcare professionals and their families within the community are vital as an aid to retention. Communities can be encouraged to make efforts to include professionals and their families in local activities and integrate them in social networks. Primary care organizations could provide programs offering 'meet and greet' sessions and crisis assistance.

10.1.2 Conclusions: Comparison of RPAP With the Experience of Other Countries

There is one key conclusion we can draw from our findings in this section:

1. Many of RPAP's programs are similar to initiatives that are being implemented in the United States and Australia, and can be expected to be implemented in the United Kingdom.

10.1.3 Recommendations: Comparison of RPAP With the Experience of Other Countries

RECOMMENDATION #1:

It is recommended that the RPAP Program Manager continue to examine the experience of other jurisdictions in an effort to take advantage of the lessons learned and "best practice" from elsewhere in an effort to develop innovative programs/initiatives to address the major factors affecting recruitment and retention of Alberta rural physicians.