



RETENTION OF RURAL PHYSICIANS

An Action Plan for 2001-2002 and beyond

Prepared by a multi-stakeholder group of rural physicians, regional health authority representatives, community representatives and service providers to rural physicians.

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EXECUTIVE SUMMARY

An Action Plan for Rural Physician Retention, 2001-02 and Beyond was developed by the Rural Physician Action Plan through a consultative process in early 2001. The plan was developed at the direction of the RPAP Co-ordinating Committee (RPAP CC), which saw the need to develop viable and tangible retention initiatives. This was in keeping with the RPAP’s Vision (*to have the right number of physicians in the right places, offering the right services in rural Alberta*) and the Co-ordinating Committee’s mandate, as well as its current Three-Year Business Plan.

Following a literature review and extensive interview process, a multi-stakeholder meeting, attended by 20 representatives, was held March 5, 2001 to establish priorities for the plan. An RPAP 2001-02 Retention Action Plan budget is proposed for its implementation.

Representatives established short and long-term priorities from among the many options included in the *Range of Suggestions* working document that outlined recommendations gathered through the research and consultation process. They felt that immediate initiatives were necessary to deal with the situation as it currently exists, while a longer-term view was also essential to plan for deeper and more innovative system change.

The action plan includes the following priorities, which are outlined in further detail in this report.

Action	Budget (see notes)	Timeframe
Immediate		
COMMUNITY		
1. Encourage and help rural communities to develop physician retention plans.	1.	April 1, 2001 and ongoing.
FAMILY/LIFESTYLE		
2. Increase support for rural physicians and spouses of rural physicians.		April 1, 2001 start and ongoing.
2.1 Increase support for spouses of physicians, in particular through localized area support networks organized by the Rural Physician Spousal Network.	Incl. in 2001-02 RPSN budget of \$57,100	
2.2 Enhance the RPAP’s collaboration with the AMA’s Physician and Family Support Program (PFSP).	1., 3.	
2.3 Provide whatever assistance is feasible to help spouses find meaningful employment.	1.	
2.4 Organize a comprehensive orientation program for new rural physicians, their spouses and families.	1.	

PROFESSIONAL		
3. Develop community-building processes among physicians to make practice more collegial and less onerous.	1., 3.	April 1, 2001 start and ongoing.
4. Pilot an incentive program for longer-term rural physicians, with an emphasis on those in more remote areas.	1.	April 1, 2001 to start planning.
<i>Long-Term</i>		
PROFESSIONAL		
5. Convene a group of innovative yet practical thinkers to consider innovative ways to build a ‘framework’ of a new health system that will enhance care, provide the required critical mass of physicians and reduce workloads to acceptable levels.	1.	April 1, 2001 to start planning.
<i>Communication and Research</i>		
Implement a communication strategy for the retention action plan.	2.	Starting April 1, 2001
Conduct Alberta-specific research on retention.	1.	Starting April 1, 2001
<i>Enhancements</i>		
Hold a focus group with early career physicians and their spouses to validate action plan with this group.	1.	By June 1, 2001
Define “retention” goals and “rural/remote.”	n/c	During 2001
Define planned outcomes and evaluation criteria.	n/c	During 2001

Notes:

1. Included in proposed 2001-02 Retention Action Plan budget of \$400,000.
2. Included in proposed 2001-02 RPAP budget.
3. In collaboration with the PFSP.

It was emphasized throughout this action plan development process that the factors influencing physician recruitment and retention are multi-factorial, involving professional, family/lifestyle and community issues. There are no ‘magic bullets’ or uniform solutions. Therefore, the range of solutions that need to be offered must be viewed as a menu or tapestry from which community and physicians can choose.

INTRODUCTION AND BACKGROUND

At the June 2000 planning retreat of the RPAP Co-ordinating Committee (RPAP CC), the Committee was unanimous on the need to develop viable and tangible retention initiatives. This was in keeping with the RPAP's Vision (*to have the right number of physicians in the right places, offering the right services in rural Alberta*) and the Co-ordinating Committee's mandate, as well as its current Three-Year Business Plan.

The RPAP Vice-Chair Dr. Odell Olson accepted leadership of the initiative, and the RPAP Program Manager, David Kay, contracted with *tt Communication* to assist in development of a rural physician retention plan. The process was to involve:

- 1. Information and idea-gathering**
 - Review relevant literature and background information on the issue.
 - Interview and gather information from relevant organizations – Rural Locum Program; Physician and Family Support Program; the Alberta Medical Association; College of Physicians and Surgeons of Alberta; College of Family Physicians of Canada, Alberta Chapter; AMA Section of Rural Medicine; individuals involved in rural issues with both Faculties of Medicine.
 - Interview individual rural physicians throughout Alberta.
 - Interview or obtain feedback from Regional Medical Directors, Regional Health Authority representatives (CEOs and other), and community representatives.
 - Post a questionnaire about retention initiatives on the RPAP web site, with notification through the virtual library, ruralnet e-mail discussion group and Rural Physician Spousal Network e-mail discussion group.
- 2. Development of draft action plan or outline of options**
 - Gather issues and suggested initiatives into themes and present them in a draft plan that includes the range of suggestions gathered through the research.
- 3. Consensus from multi-stakeholder group**
 - Hold a multi-stakeholder meeting to review the range of options, further develop concepts, identify priorities and suggest implementation strategies.
- 4. Consideration of plan by RPAP Co-ordinating Committee**
 - Present the retention plan to RPAP CC on March 15, 2001.

This report brings the process to the last step.

BASIS FOR THE PLAN

The rural physician retention plan is being built on the foundation of a number of commonly shared beliefs or principles. These beliefs were generally expressed, either directly or indirectly, by people involved in the interview and research process.

Shared beliefs:

- Retention is a complex issue, with no easy solutions.
- Retention is linked to and cannot be separated from medical student selection, medical education and physician recruitment.
- Solutions must be of a lasting long-term nature, as opposed to ‘quick fixes.’
- Considerable variability exists among communities and locations, showing the need for flexibility in retention initiatives.
- Individual physicians have different wants and needs.
- The professional, family/lifestyle and community areas of influence on physician retention (and recruitment) are all important.
- A matrix of solutions is required to address all three areas.
- Many ‘intangibles’ are involved in the retention of rural physicians.
- Many things that influence the retention of rural physicians are not in the RPAP’s direct control, but the RPAP can be a facilitator for rural physician recruitment and retention initiatives.

Positive initiatives:

Participants also agreed that many of the RPAP’s current initiatives positively affect rural physician retention. Positive initiatives include:

- The Rural Locum Program and its expansion to seniors
- Rural on-call payments
- Skills enhancements program
- RPAP-funded medical school training initiatives, such as the “rural stream” and rural rotations
- On-line medical education advances
- Preliminary work on the spousal program

LITERATURE REVIEW FINDINGS

A review of literature related to the issue of retention presented some interesting (and at times, conflicting) background for the RPAP's development of a rural physician retention plan. In addition, a review of existing Alberta material provided some focus for the process.

In general, the literature demonstrated that three areas affect physicians' decisions about whether to stay in rural practice:

- Professional
- Family/lifestyle
- Community

A few highlights follow.

In Canada, the *Report of the Advisory Panel on the Provision of Medical Services in Underserved Regions* (1992) of the Canadian Medical Association, recommended:

- Regionalized delivery of health services
- Use of incentive programs to address retention in underserved regions (and investigation of sabbaticals)
- Coordinated locum services
- Medical education availability and postgraduate rural training programs

A further CMA study, described in *Politics of rural health care: recruitment and retention of physicians* (1993), identified factors that influence physicians to stay rural:

- The availability of additional colleagues
- Locum tenens programs
- Opportunity for group practice
- Specialist services
- Alternative compensation mechanisms
- Continuing medical education opportunities
- Improved health care facilities & emergency transportation

Key modifiable factors affecting rural physician retention were considered to be:

- Medical education
- Group practice opportunities
- Improved hospital facilities
- Reasonable working conditions
- Financial incentives
- Spousal factors

Community and Self: Concepts for Rural Physician Integration and Retention (1997) elaborated on the perspective that integration of physicians within rural communities is the basis for retention. Both the professional community and community-at-large are discussed. Some conclusions include:

- A more homogeneous medical community makes for a greater level of cooperation and mutual assistance.
- The small medical practice acts as the most meaningful type of medical community for rural doctors.
- The physician's family's ability to connect with other groups and the local culture is vitally important to the physician's developing self and integration.
- Education of the community-at-large about local medical care and its issues is necessary.
- The development of cooperation, responsibility and collective action can assist in retaining doctors in rural places.

Rural Physician Satisfaction: Its Sources and Relationship to Retention (1996), focused directly on issues that impact retention, and although done in the United States, may be related to the Canadian context. From among many factors, its authors found that retention was independently associated with only:

- Physicians' satisfaction with their communities
- Physicians' opportunities to achieve professional goals
- Physicians' satisfaction with earnings (borderline statistical significance)

Physicians in solo practices were less satisfied with all three areas of satisfaction. Physicians raised in rural areas were no more or less satisfied with their communities. To the authors' surprise, physicians who were more satisfied with having adequate personal time away from work demonstrated shorter retention; this required further study. They also concluded that retention was not associated with degree of satisfaction with access to consultants, the medical literature or continuing medical education opportunities.

The paper concluded, "There are no magic bullets to make rural physicians satisfied in all ways. Nevertheless there are identified approaches to elevate the specific aspects of rural physicians' satisfaction important to their retention." Suggested action areas included:

- Improving physicians' satisfaction with their earnings
- Reducing on-call frequency
- More subtle and individually tailored support than that provided by across-the-board increases in incomes and improved access to the latest technology
- Improving satisfaction with their communities – "from forming strong, positive relationships with its people and organizations, and by gaining a sense of belonging."

Some RPAP-supported research in Alberta also provided an important local perspective. *Pockets of Good News, Physician recruitment in rural Alberta* (1994) demonstrated the importance of matching what physicians need and want with what communities need and want. A 2000 communications audit of RPAP prepared for the RPAP CC concluded, "there is a strong need for RPAP to become much more involved in retention issues... What is needed are strategies to keep current rural physicians and their families happy."

MULTI-STAKEHOLDER MEETING

A multi-stakeholder meeting, attended by 20 representatives, was held March 5, 2001 to provide input to the development of the action plan for rural physician retention.

The process for the meeting, facilitated by Burke and Associates, was:

- Identify criteria for assignment of priorities
- Identify priorities from among the *Range of Suggestions* working document
- Recommend implementation strategies and issues

Criteria for assignment of priorities

Discussion led to the following suggested criteria for the assignment of priorities:

- Successful implementation would result in RPAP's goals for "retention"* being achieved.
- Implementation of the strategy would be effective in increasing the retention of "rural"* physicians.
- The strategy facilitates meeting the unique needs of physicians in unique communities.
- RPAP has the ability to influence what is being proposed.
- RPAP should be involved in the initiative.
- There is good potential to implement the initiative successfully.
- The cost of the strategy results in a good return on the investment.
- The strategy addresses and/or is complementary to the needs of the regional health authority and its communities.
- The community is receptive to the initiative.

*Representatives noted and discussed the need for definition.

PRIORITIES

Representatives established short and long-term priorities from among the many options included in the *Range of Suggestions* working document (Appendix B). They felt that immediate initiatives were necessary to deal with the situation, as it currently exists, while a longer-term view was also essential to plan for deeper and more innovative system change.

Immediate (starting with the most favored option)

Community

- **Encourage and help rural communities to develop physician retention plans.** Participants felt that a top priority was to work with communities (through their RHAs) and involve them in supporting physicians through recruitment and retention.

Family/lifestyle

- **Increase support for rural physicians and spouses of rural physicians through such things as enhanced activity and collaboration with the Rural Physician Spousal Network and Physician and Family Support Program.** Participants agreed on the importance of ensuring physicians and their families have adequate networking opportunities and preventive self-help measures to thrive in the rural environment, should they wish to take advantage of them.

Professional

- **Develop community-building processes among physicians to make practice more collegial and less onerous.** Participants agreed with the concept of proactively building “communities” of physicians who work together in ways that enhance professional and personal satisfaction.
- **Pilot an incentive program for longer-term rural physicians, with an emphasis on those in more remote areas.** Participants supported the concept of a “reward” for working longer-term in rural (especially remote) Alberta. They felt this could be based on a sabbatical concept (for professional or personal reasons), and financial incentives, which recognize varying levels of long service.

Long-term

- **Convene a group of innovative yet practical thinkers to consider innovative ways to build a ‘framework’ of a new health system that will enhance care, provide the required critical mass of physicians and reduce workloads to acceptable levels.** Meeting participants agreed that long-range “zero-based” thinking is necessary to find new ways of doing things. This included the need for such broad considerations as how to provide adequate medical infrastructure and supporting resources, recognize special skills among rural physicians, ensure Telehealth is meeting needs and adequately preparing new physicians for rural practice.

ACTION PLAN

Immediate

(starting with the most favored option)

COMMUNITY

1. Encourage and help rural communities to develop physician retention plans.

Participants felt that a top priority was to work with communities and involve them in supporting physicians through recruitment and retention. They saw the importance of involving the community in developing ways to ease physicians and their families into and keep them content within the community. This is essentially assisting communities with marketing, which starts at recruitment and continues into retention.

Local governments were generally felt to be the most effective level of contact and involvement. When communities are informed about what they can do and its importance (with recognition that funding is not what's required), they are usually interested and supportive. Consort was named as an example. Such work would need to occur in conjunction with RHAs.

Implementation activities include:

- Encourage communities to be flexible to meet physicians' and their families' needs and find ways to deepen a physician's commitment to the community. Examples of ways to help include providing interest-free loan or subsidized mortgage to provide an incentive to build a house, contract to buy-back a home if the physician leaves after five years, etc.
- Help communities recognize ways of maintaining ongoing interest in and support for the medical community, such as by providing weekends away, involving the spouse, etc.
- Help communities to realistically consider what level of medical services they want to be offered, and what the community will be able to support.
- Educate communities about how to use physician resources most effectively.
- Involve communities in orientation programs for rural physicians.
- Inform the communities about steps they can take to keep physicians (which would vary by community but could include anything from owning the medical clinic to organizing a community welcoming/orientation get-together for a new physician to inviting the spouse to a recreational activity.)
- Inform the communities about and encourage them to provide the social support structures needed by spouses, i.e. help with childcare, friendships, and social outlets.
- Educate communities about boundary issues in their use of physician resources.
- Identify and re-use successes of some communities.

Implementation strategy:

The new RPAP Rural Physician Consultant position could facilitate such initiatives. Regional Medical Directors and physicians within the communities should be involved as required.

The Consultant would establish contacts within the local governments and work with informal and formal opinion leaders in the community.

A community development type of model, as used within community health, should be followed.

Current status:

Two RPAP Rural Physician Consultants (one north and one south) begin April 1. This will be among their priority activities.

Funding requirement:

Included in proposed 2001-02 Retention Action Plan budget.

Responsibility and timeframe:

RPAP – beginning April 1, 2001 and ongoing

Reference to *Range of Suggestions* working document – Appendix B:

Based on recommendation C-3, with deletion of references to Community Health Councils and with reference to recommendations C-1, C-2, B-4, C-5.

FAMILY/LIFESTYLE

2. Increase support for rural physicians and spouses of rural physicians through such things as enhanced activity and collaboration with the Rural Physician Spousal Network and the Physician and Family Support Program.

Participants agreed on the importance of ensuring physicians and their families have adequate networking opportunities and preventive self-help measures to thrive in the rural environment.

Survey respondents most often identified this factor as most important (if they didn't say that all three factors were equally important).

Specific actions include the following:

2.1 Increase support for spouses of physicians, in particular through localized area support networks organized by the Rural Physician Spousal Network.

Participants acknowledged the importance of happy spouses to the satisfaction and retention of rural physicians. Many participants were aware of the Rural Physician Spousal Network, an RPAP initiative, and saw it as a good start but

needing “more horsepower” and continued growth. The need for adequate funding was emphasized.

Implementation activities include:

- Facilitate development of area support networks. Support networks, organized and led by local spouses through the Rural Physician Spousal Network (RPSN), were seen as a way of getting more spouses involved and providing concrete and meaningful peer support. The networks could be developed through:
 - Organization of support groups in towns, regions and sectors of the province.
 - Leadership by a specific spouse for each area.
 - Gathering of volunteers to form a telephone network.
 - Foster a critical mass to build upon.
 - Organization of meetings for each area, with agenda and style to suit local needs.
 - Developing a ‘how to’ guide for local network development to be used by local spouse leader.

The Rural Physician Spousal Network has already set a goal for 2001-2 of holding three regional meetings (north, south, central). This may be expanded.

- Combine spousal get-togethers with CME whenever possible, as an additional opportunity for spouses to meet within a region or provincially.
- Continue to provide spousal get-togethers at existing conferences.
- Consider industry sponsorships.
- Further develop the RPSN database.
- Consider involving other professions’ spouses in the communities.
- Conduct a needs assessment within families to ensure needs are recognized and met.
- Continue collaboration with the Physician and Family Support Program (PFSP).

Implementation strategy:

The Rural Physician Spousal Network Advisory Committee will provide guidance and leadership for these initiatives. Primary support and organization will be provided by the RPSN Administrator, with assistance from the RPAP office. The new RPAP Rural Physician Consultants will also provide valuable assistance and liaison in the rural communities.

Current status:

The Rural Physician Spousal Network Advisory Committee currently has six members, representing north, central and south areas, and is chaired by Gail Bablitz of Whitecourt. Terri Taylor acts as the Network’s Administrator, working 2-5 days a month. They have submitted a 2001-02 program and budget to the RPAP Coordinating Committee, which includes three regional meetings, one spouse-only retreat and one family retreat, along with numerous conference-

associated get-togethers. The Network collaborates with the Physician and Family Support Program in planning and implementing many of its events.

The RPSN's biggest challenge is gathering sufficient spousal involvement to move progress forward in the local areas.

Funding requirement:

Budget of \$57,100 for 2001-02 submitted to RPAP.

Responsibility and timeframe:

RPAP for funding the Rural Physician Spousal Network

The RPSN for implementing the activities, using consultants as required and with an emphasis on grassroots involvement.

Continuing and ongoing with increased momentum.

Reference to *Range of Suggestions working document* – Appendix B:

Based on recommendation B-1, with reference to B-2.

2.2 Enhance the RPAP's collaboration with the AMA's Physician and Family Support Program.

Many interview participants regarded the PFSP as a very useful service. They tended to view it as a program for those in crisis rather than with a preventive focus. The PFSP itself considered that it could collaborate with and provide required services to the RPAP.

Participants in the March 5 planning meeting saw this collaboration as very important and beneficial.

Implementation activities include:

- The RPAP could engage the PFSP as a service provider for stress/balance/isolation materials, counselling and workshops specifically targeted for rural physicians and their families. The focus would be on preventive self-help measures to living and prospering in rural communities; providing tools to help physicians and families take responsibility for their own happiness.
- The RPAP could use the PFSP's expertise in mediation and facilitating win-win resolutions for RHA, community and physician-physician disputes.
- The RPAP could provide rural-specific feedback and suggestions to the PFSP for its programming (including whether specific programming is required for new IMGs).
- The RPAP could promote increased awareness of the PFSP's services among rural physicians and their families.
- The PFSP's preventive focus would be promoted.

Current status:

The RPAP Program Manager and PFSP Program Manager have already begun discussing future collaborative efforts. The PFSP has supported programming for the Rural Physician Spousal Network financially and through its expertise.

Funding requirement:

Included in the proposed 2001-02 Retention Action Plan budget.

Responsibility and timeframe:

RPAP Program Manager to implement and foster relationships – April 1, 2001 and ongoing. A mid-April meeting between PFSP and RPAP Rural Physician Consultants is planned.

Reference to *Range of Suggestions* working document – Appendix B

Based on recommendation B-2.

2.3 Provide whatever assistance is feasible to help spouses find meaningful employment.

Participants recognized that spousal employment is a significant issue – but a difficult one to influence. Examples of barriers, such as union regulations for health care workers, were mentioned. Others pointed out the difference between Alberta communities' lack of involvement and the proactive approach in the United States. Interestingly, most spouses interviewed did not expect or want intervention on their behalf. They saw this as a factor that 'came with the territory' and that families would have to deal with in their own ways.

Implementation activities include:

- At time of recruitment, encourage the region/community/other physicians to use their influence to meet the spouse's needs.
- The RPAP, in conjunction with the other partners (e.g. RHAs, AAHEPP) should talk with unions about how their policies could influence spousal employment.
- The RPAP, in collaboration with the community, could provide guidance on options available, such as volunteer work, distance education, etc.
- The RPAP should partner with others, such as municipalities and regional health authorities.

Current status:

New initiative.

Funding requirement:

Included in the proposed 2001-02 Retention Action Plan budget.

Responsibility and timeframe:

The RPAP Program Manager will be responsible for implementing, through direction to the Rural Physician Consultants.

Reference to *Range of Suggestions* working document – Appendix B

Based on recommendation B-5.

2.4 Organize a comprehensive orientation program for new rural physicians, their spouses and families.

Some participants suggested that an improved orientation process for new physicians, particularly IMGs but similar may apply to Alberta graduates, would ease integration of the physician and family into the medical community and community-at-large. It may also be useful to consider what the needs are now for physicians who came to Alberta one or two years ago; a study of IMGs and retention-type issues, supported by the RPAP and to be released soon, will likely provide some guidance.

Implementation activities include:

- Organize in collaboration with communities, RHAs and local physicians a personal approach to greeting and assisting new physicians. For example, ensure someone greets them at the airport, takes them to the College of Physicians and Surgeons to initiate processes there, provide banking and other information.
- Prepare a booklet of information to orient physicians and their families to such things as day care centres, banks, housing prices, schooling, educational options, moving companies, etc. Provide as much information as possible before they arrive.
- Pair each new physician with an experienced physician of similar background in another community to act as mentor and confidante.
- Ask the RPSN to build a ‘library’ of suggestions for different audiences: how to overcome the problems of adjusting for the physician and spouse, and how to welcome newcomers for communities and RHAs.
- Continue to develop and support efforts to prepare new medical graduates for rural practice.

Implementation strategy:

The RPAP Program Manager will oversee implementation through involvement of the Rural Physician Spousal Network, Rural Physician Consultants and/or other consultants as required. Liaison with medical schools will also be required. A similar item is identified in the 2000 RPAP Communications Plan.

Current status:

New initiative.

Funding requirement:

Included in the proposed 2001-02 Retention Action Plan budget.

Responsibility and timeframe:

RPAP – program prepared by Fall 2001 and ongoing.

Reference to *Range of Suggestions* working document – Appendix B.

Based on recommendation B-4, with reference to A-12.

PROFESSIONAL**3. Develop community-building processes among physicians to make practice more collegial and less onerous.**

Participants agreed with the concept of proactively building “communities” of physicians who work together in ways that enhance professional and personal satisfaction.

Many suggestions during interviews related to the concept of building “communities” of physicians who work together. This could reduce the on-call burden and professional isolation while providing an opportunity to enhance skills. Examples included three 2-physician communities who joined together to share on-call; physicians in a practice who share rather than ‘own’ patients; and the idea of physicians within a community each developing a special skill, such as geriatric or exercise stress testing, to “minimize referrals outside the community and add prestige.” One participant recognized that “so much of it comes down to intangibles – relationships.”

Implementation activities include:

- Encourage a co-operative environment among physicians; provide practice and collegial support to bring people together.
 - Communication about ‘success stories’
 - Encourage new physicians to buy into local practices (and existing physicians to provide such an opportunity) rather than overhead payment methods
 - Find innovative ways for one- and two-physician communities to collaborate with others
- PFSP should conduct community check-ups to assess the ‘health’ of the relationships within the medical communities. Be proactive; do not wait for things to happen. Provide ‘pre-toxic’ interventions when required.
- Provide mediation services (through Physician and Family Support Program) when required to settle disputes among physicians.
- PFSP should provide regular presentations/discussions about professionalism (our behaviour with one another).
- Professional behaviour should also be taught to medical students.
- Develop more regional collegiality, through such things as even a once-yearly regional professional/social get-together that includes physicians and spouses

- Encourage development of special interests/skills among physicians, resulting in a community of physicians, each with a different special skill.

Implementation strategy:

RPAP Program Manager will work with the PFSP Program Manager to implement. Collaboration with Regional Medical Directors and local physicians will be an important aspect. Rural Physician Consultants may be able to provide some liaison, information-gathering assistance.

Medical schools will be approached about the importance of professionalism training.

Current status:

New initiative.

Funding requirement:

Included in the 2001-02 Retention Action Plan budget.

Responsibility and timeframe:

RPAP and PFSP – April 1, 2001 start and ongoing.

Reference to *Range of Suggestions* working document – Appendix B.

Based on recommendation A-2, with reference to A-12.

4. Pilot an incentive program for longer-term rural physicians, with an emphasis on those in more remote areas.

Participants in the March 5 meeting supported the concept of a “reward” for working longer-term in rural (especially remote) Alberta. They were provided with three options to consider – sabbaticals, remote incentives and long-term incentives – and ultimately felt a blended program may be best. It could be based on a sabbatical concept (for professional or personal reasons), with financial recognition for varying levels of long service and applying only to remote communities, at least to start.

Sabbaticals seemed to offer both financial (if the Province contributed some funds) and lifestyle incentives. A potential ‘downside’ also was identified, in that some physicians may choose not to return after their sabbatical.

The complexity of this recommendation was recognized during the March 5 discussions. It was felt that detailed investigation and consideration would have to be given before implementation.

Implementation activities include:

Program development should include consideration of the following challenges:

- Defining sabbaticals and length (whether optional three months/six months/year)
- Recognition for pre-existing service when it is introduced.

- Recognition that a staggered process is required.
- Recognition of longer-term physicians, allowing them to go first.
- The potential for using it as a retirement plan.
- Having adequate coverage for people away.
- Recognizing that there could be urban resistance if this applied to all rural.
- Requirement for determining what sabbaticals may be used for (avoidance of burn-out versus increase in skills – or both)
- Investigation of tax implications.
- Possibility as an RESP (Registered Education Savings Program) for adults.
- Consideration of how matching funds would work.
- Relationship or possible tie-in to existing Enrichment programs.

Implementation strategy:

RPAP will establish a working group, including RPAP, Alberta Section of Rural Medicine, Alberta Medical Association and Alberta Health and Wellness representatives to further develop this program.

Current status:

A proposal prepared by Dr. David O’Neil, and now out-of-date, can be examined as a starting point.

Funding requirement:

Development costs included in proposed 2001-02 Retention Action Plan budget.

Responsibility and timeframe:

RPAP to coordinate – April 2001 start.

Reference to *Range of Suggestions* working document – Appendix B.

Based on recommendation A-1.

Long-Term

PROFESSIONAL

5. **Convene a group of innovative yet practical thinkers to consider innovative ways to build a ‘framework’ of a new health system that will enhance care, provide the required critical mass of physicians and reduce workloads to acceptable levels.**

Meeting participants agreed that long-range “zero-based” thinking is necessary to find new ways of doing things.

It was felt that such a long-range ‘think tank’ would encompass long-term solutions to many of the specific recommendations offered in the *Range of Suggestions* working document including:

- Investigate such innovations as new roles and licensing possibilities for IMG physicians who are not currently granted license to practice, encourage the use of alternative payment mechanisms, develop more regional ‘team’ approaches, etc.
- RPAP should reinforce to the Minister of Health and Wellness and the rural RHAs the need for adequate medical infrastructure and supporting resources.
- Develop easier access to specialists.
- Provide recognition for special skills.
- Promote a more concerted effort to provide and use Telehealth.
- Continue to develop and support efforts to promote rural practice as a viable option and to prepare new physicians for it.
- Foster discussions that could lead to development of a community health care approach in rural areas, or a ‘rural health plan’ rather than a ‘rural physician plan.’

It was also felt that, although the results of such an activity would be long-term, work should begin immediately.

Implementation activities include:

Convene a group of innovative yet practical thinkers to build a ‘framework’ of a new system, and explore models of health care delivery.

Deliberations could include an examination of such issues as:

- Ways to increase the critical mass of physicians and develop other system-wide changes to enhance care and reduce workloads (through use of professionals, alternative payment mechanisms, etc.)
- The need for adequate medical infrastructure and supporting resources.
- Ease of access to specialists
- Recognition for and development of special skills.
- Promotion of a more concerted effort to provide and use Telehealth.
- Promotion of rural practice as a viable option and to prepare new physicians for it.
- Development of a community health care approach in rural areas, or a ‘rural health plan’ rather than a ‘rural physician plan.’

Current status:

New initiative.

Funding requirement:

Included in proposed 2001-02 Retention Action Plan budget.

Responsibility and timeframe:

RPAP to convene and lead the process – April 2001 start and throughout 2001 to March 31, 2002.

Reference to *Range of Suggestions* working document – Appendix B:

Based on recommendation A-3, with reference to recommendations A-4, A-5, A-9, A-11 and A-12.

COMMUNICATION AND RESEARCH

The importance of communicating about the RPAP's emphasis on retention and the need for further research also were emphasized through the action plan development process.

COMMUNICATION

Suggestions about the RPAP's communication with its many audiences emerged from the retention discussions. A full communications strategy will be developed through the RPAP's communications plan. Suggestions include:

- Communicate about what works well, through newsletters, web site, manuals and face-to-face. For example, the RPAP could regularly highlight:
 - ways that physicians are working together to reduce on-call and provide quality care
 - people's successes in dealing with their children's educational challenges
 - how physicians and their families have gotten involved in their communities
 - what some RHAs and communities are doing to involve and integrate their physicians
- Increase community education and foster community action to preserve and nurture rural health care.
- Call for and help initiate more public education about wise use of health care resources etc.
- Establish relationships at all levels (RHAs, physicians, Regional Medical Directors, Community Health Councils, other health care providers etc.), to enhance understanding of physicians' issues and lead toward ongoing productive solutions.
- Provide positive affirmations to physicians that "Yes, you are important. You are needed and appreciated." Show through examples.
- Involve physicians and other audiences in continually assessing and updating the retention plan. Small groups could work on specific projects. Accomplishments and updates should be provided regularly through ongoing RPAP communication vehicles, including face-to-face.

Current status:

New initiative, but also recognized in part in the 2000 RPAP Communications Plan.

Funding requirement:

Included in the 2001-02 proposed RPAP budget.

Responsibility:

RPAP - begin April 1, 2001 and ongoing.

RESEARCH

The need for specific research into retention issues was highlighted by some participants, and was obvious through a review of the literature.

Participants at the March 5 planning meeting agreed:

- The RPAP should support coordinated and disciplined research on the key factors for retention of physicians in rural practice settings. The research should be led by RPAP and contracted out (e.g. through the Alberta Family Practice Research Network).

Implementation activities include:

- Update 1994 “Pockets of Good News” recruitment and retention study.
- Publicize current research activities that impact retention.

Current status:

New initiative, with updates.

Funding requirement:

Included in the 2001-02 proposed Retention Action Plan budget.

Responsibility and timeframe:

RPAP - starting April 1, 2001 and ongoing.

FUTURE ENHANCEMENTS

Discussions at the planning meeting brought forward additional considerations that could enhance the action plan on rural physician retention.

Input from new graduates and early career physicians.

The multi-disciplinary group noted that additional feedback would be beneficial, perhaps through a focus group, to ensure the action plan meets the needs of the new generation of physicians and their families.

Action: Input will be obtained from a focus group of early career physicians and their spouses following review by the RPAP Coordinating Committee.

Definitions.

The need for some definitions was highlighted, specifically for:

- Retention
- Rural

With regard to retention, it was suggested that a specific target might not be feasible or desirable. Rather, comparative goals may be preferable (i.e. results with the action plan versus without it.) Some members also noted the variability within Alberta – while three-year retention may be good in one community, it would not be an adequate goal in another.

Action: Will be done in 2001.

Evaluation and measurement.

Definition of planned outcomes (as above) and evaluation/measurement mechanisms would provide additional validity to the plan.

Action: Planned outcomes and evaluation criteria will be defined as part of the next RPAP 3-year Business Plan.

Non-priority recommendations from the *Range of Suggestions* working document.

Participants at the planning did not eliminate any options included in the working document. Therefore, on a less-urgent basis, the RPAP could pursue the following recommendations:

- Encourage RHAs to involve physicians more in health care planning. (Recommendation A-6)
- Develop guidelines for contracts for use with new physicians in particular. (Recommendation A-7, with some revision)
- Increase opportunities for retraining. (Recommendation A-8)
- Encourage improvements in CME, with recognition that a current RPAP evaluation of CME programs for rural physicians may provide more detailed insight on this issue. (Recommendation A-10)

- Consider initiatives that may be of particular relevance to retention of IMGs. (Recommendation A-13). Preliminary results from a recent study on IMGs, reported at the meeting, indicate that their needs and possible solutions are not particularly unique from those gathered through this action planning process.
- Expand the Rural Locum Program to provide increased opportunity for much-needed breaks for rural physicians. (Recommendation B-3)

ACTION PLAN AT-A-GLANCE

Action	Budget (see notes)	Timeframe
Immediate		
COMMUNITY		
1. Encourage and help rural communities to develop physician retention plans.	1.	April 1, 2001 and ongoing.
FAMILY/LIFESTYLE		
2. Increase support for rural physicians and spouses of rural physicians. 2.2 Increase support for spouses of physicians, in particular through localized area support networks organized by the Rural Physician Spousal Network. 2.2 Enhance the RPAP’s collaboration with the AMA’s Physician and Family Support Program (PFSP). 2.3 Provide whatever assistance is feasible to help spouses find meaningful employment. 2.4 Organize a comprehensive orientation program for new rural physicians, their spouses and families.	Incl. in 2001-02 RPSN budget of \$57,100 1., 3. 1. 1.	April 1, 2001 start and ongoing.
PROFESSIONAL		
3. Develop community-building processes among physicians to make practice more collegial and less onerous.	1., 3.	April 1, 2001 start and ongoing.
4. Pilot an incentive program for longer-term rural physicians, with an emphasis on those in more remote areas.	1.	April 1, 2001 to start planning.
Long-Term		
PROFESSIONAL		
5. Convene a group of innovative yet practical thinkers to consider innovative ways to build a ‘framework’ of a new health system that will enhance care, provide the required critical mass of physicians and reduce workloads to acceptable levels.	1.	April 1, 2001 to start planning.
Communication and Research		
Implement a communication strategy for the retention action plan.	2.	Starting April 1, 2001
Conduct Alberta-specific research on retention.	1.	Starting April 1, 2001
Enhancements		
Hold a focus group with early career physicians and their spouses to validate action plan with this group.	1.	By June 1, 2001
Define “retention” goals and “rural/remote.”	n/c	During 2001
Define planned outcomes and evaluation criteria.	n/c	During 2001

Notes:

1. Included in proposed 2001-02 Retention Action Plan budget of \$400,000.
2. Included in proposed 2001-02 RPAP budget.
3. In collaboration with the PFSP.

It was emphasized throughout this action plan development process that the factors influencing physician recruitment and retention are multi-factorial, involving professional, family/lifestyle and community issues. There are no ‘magic bullets’ or uniform solutions. Therefore, the range of solutions that need to be offered must be viewed as a menu or tapestry from which community and physicians can choose.

APPENDIX A

Attendance at March 5, 2001 multi-disciplinary planning meeting

Name	Community
Mrs. Gail Bablitz	Chair, Rural Physician Spousal Network (RPSN) Advisory Committee, Whitecourt
Dr. Barend Olivier	Whitecourt/Fox Creek
Dr. David O’Neil	Trochu
Dr. Luxie Trachsel	AED Professional Affairs, AMA
Mr. Geoff Weber	Regional Services Officer, Aspen RHA
Mrs. Brenda Gilboe	Coordinator RLP, AMA
Dr. George Goldsand	Director, UofA Office of Rural Health
Dr. John Hnatuik	RPAP Skills Broker, Provost
Mrs. Lara Van Wyk	Rural Physician Spousal Network
Dr. Gary Nelson	RPAP CC, AMA Section of Rural Medicine, Whitecourt
Dr. David Belcher	Drayton Valley
Dr. Gisele Microys	Physician & Family Support Program (PFSP)
Dr. Maureen Topps	IMG Study, Airdrie
Dr. Tony Mucciarone	Bassano
Mr. James McLaughlin	Mannville
Dr. Ron Gorsche	RPAP Skills Broker, High River
Dr. Guy Gokiart	Westlock
Mr. Brian Hrab	RPAP CC, CEO, Peace RHA
Dr. David Topps (for Dr. John Toews)	Rural Coordinator, UofC Family Medicine
Dr. Odell Olson	Vice Chair, RPAPCC, Regional Medical Director, East Central RHA, Camrose

APPENDIX B

Range of Suggestions working document



RETENTION OF RURAL PHYSICIANS

An Action Plan for 2001-2002 and beyond

*Range of Suggestions
for review March 5, 2001
at a multi-stakeholder planning meeting*

INTRODUCTION AND BACKGROUND

At the June 2000 planning retreat of the RPAP Co-ordinating Committee (RPAP CC), the Committee was unanimous on the need to develop viable and tangible retention initiatives. This was in keeping with the RPAP's Vision (*to have the right number of physicians in the right places, offering the right services in rural Alberta*) and the Co-ordinating Committee's mandate, as well as its current Three-Year Business Plan.

The RPAP Vice-Chair Dr. Odell Olson accepted leadership of the initiative, and the RPAP Program Manager, David Kay, contracted with *tt Communication* to assist in development of a rural physician retention plan. The process was to involve:

1. Information and idea-gathering

- Review relevant literature and background information on the issue.
- Interview and gather information from relevant organizations – Rural Locum Program; Physician and Family Support Program; the Alberta Medical Association; College of Physicians and Surgeons of Alberta; College of Family Physicians of Canada, Alberta Chapter; AMA Section of Rural Medicine; individuals involved in rural issues with both Faculties of Medicine.
- Interview individual rural physicians throughout Alberta.
- Interview or obtain feedback from Regional Medical Directors, Regional Health Authority representatives (CEOs and other), and community representatives.
- Post a questionnaire about retention initiatives on the RPAP web site, with notification through the virtual library, ruralnet e-mail discussion group and Rural Physician Spousal Network e-mail discussion group.

2. Development of draft action plan or outline of options

- Gather issues and suggested initiatives into themes and present them in a draft plan that includes the range of suggestions gathered through the research.

3. Consensus from multi-stakeholder group

- Hold a multi-stakeholder meeting to review the range of options, further develop concepts, identify priorities and suggest implementation strategies.

4. Consideration of plan by RPAP Co-ordinating Committee

- Present the retention plan to RPAP CC on March 15, 2001.

This report represents completion of the first two steps.

The multi-stakeholder meeting is planned for Monday, March 5, 2001.

BASIS FOR THE PLAN

The rural physician retention plan is being built on the foundation of a number of commonly shared beliefs or principles. These beliefs were generally expressed, either directly or indirectly, by people involved in the interview and research process.

Shared beliefs:

- Retention is a complex issue, with no easy solutions.
- Retention is linked to and cannot be separated from medical student selection, medical education and physician recruitment.
- Solutions must be of a lasting long-term nature, as opposed to ‘quick fixes.’
- Considerable variability exists among communities and locations, showing the need for flexibility in retention initiatives.
- Individual physicians have different wants and needs.
- The professional, family/lifestyle and community areas of influence on physician retention (and recruitment) are all important.
- A matrix of solutions is required to address all three areas.
- Many ‘intangibles’ are involved in the retention of rural physicians.
- Many things that influence the retention of rural physicians are not in the RPAP’s direct control, but the RPAP can be a facilitator for rural physician recruitment and retention initiatives.

Positive initiatives:

Participants also agreed that many of the RPAP’s current initiatives positively affect rural physician retention. Positive initiatives include:

- The Rural Locum Program and its expansion to seniors
- Rural on-call payments
- Skills enhancements program
- Medical school training initiatives, such as the rural stream and rural rotations
- On-line medical education advances
- Preliminary work on the spousal program

LITERATURE REVIEW FINDINGS

A review of literature related to the issue of retention presented some interesting (and at times, conflicting) background for the RPAP's development of a rural physician retention plan. In addition, a review of existing Alberta material provided some focus for the process.

In general, the literature demonstrated that three areas affect physicians' decisions about whether to stay in rural practice:

- Professional
- Family/lifestyle
- Community

A few highlights follow.

In Canada, the *Report of the Advisory Panel on the Provision of Medical Services in Underserved Regions* (1992) of the Canadian Medical Association, recommended:

- Regionalized delivery of health services
- Use of incentive programs to address retention in underserved regions (and investigation of sabbaticals)
- Coordinated locum services
- Medical education availability and postgraduate rural training programs

A further CMA study, described in *Politics of rural health care: recruitment and retention of physicians* (1993), identified factors that influence physicians to stay rural:

- The availability of additional colleagues
- Locum tenens programs
- Opportunity for group practice
- Specialist services
- Alternative compensation mechanisms
- Continuing medical education opportunities
- Improved health care facilities & emergency transportation

Key modifiable factors affecting rural physician retention were considered to be:

- Medical education
- Group practice opportunities
- Improved hospital facilities
- Reasonable working conditions
- Financial incentives
- Spousal factors

Community and Self: Concepts for Rural Physician Integration and Retention (1997) elaborated on the perspective that integration of physicians within rural communities is the basis for retention. Both the professional community and community-at-large are discussed. Some conclusions include:

- A more homogeneous medical community makes for a greater level of cooperation and mutual assistance.
- The small medical practice acts as the most meaningful type of medical community for rural doctors.
- The physician's family's ability to connect with other groups and the local culture is vitally important to the physician's developing self and integration.
- Education of the community-at-large about local medical care and its issues is necessary.
- The development of cooperation, responsibility and collective action can assist in retaining doctors in rural places.

Rural Physician Satisfaction: Its Sources and Relationship to Retention (1996), focused directly on issues that impact retention, and although done in the United States, may be related to the Canadian context. From among many factors, its authors found that retention was independently associated with only:

- Physicians' satisfaction with their communities
- Physicians' opportunities to achieve professional goals
- Physicians' satisfaction with earnings (borderline statistical significance)

Physicians in solo practices were less satisfied with all three areas of satisfaction. Physicians raised in rural areas were no more or less satisfied with their communities. To the authors' surprise, physicians who were more satisfied with having adequate personal time away from work demonstrated shorter retention; this required further study. They also concluded that retention was not associated with degree of satisfaction with access to consultants, the medical literature or continuing medical education opportunities.

The paper concluded, "There are no magic bullets to make rural physicians satisfied in all ways. Nevertheless there are identified approaches to elevate the specific aspects of rural physicians' satisfaction important to their retention." Suggested action areas included:

- Improving physicians' satisfaction with their earnings
- Reducing on-call frequency
- More subtle and individually tailored support than that provided by across-the-board increases in incomes and improved access to the latest technology
- Improving satisfaction with their communities – "from forming strong, positive relationships with its people and organizations, and by gaining a sense of belonging."

Some RPAP-supported research in Alberta also provided an important local perspective. *Pockets of Good News, Physician recruitment in rural Alberta* (1994) demonstrated the importance of matching what physicians need and want with what communities need and want. A 2000 communications audit of RPAP prepared for the RPAP CC concluded, "there is a strong need for RPAP to become much more involved in retention issues... What is needed are strategies to keep current rural physicians and their families happy."

RANGE OF OPTIONS: RETENTION PLAN

Participants in interviews and other feedback mechanisms suggested a range of options for retaining rural physicians. Suggestions that received significant support are outlined below for consideration at the March 5 RPAP-sponsored multi-stakeholder planning meeting.

Following the March 5 meeting, each accepted recommendation would be further detailed with:

- Implementation strategy
- Current status
- Responsibility, budget and timeframe

A. PROFESSIONAL

Recommendations:

A-1. Provide an incentive for longer-term rural physicians, with some differentiation for those in more remote areas.

Considerable support existed for the concept of some sort of “reward” for working longer-term in rural Alberta. In addition, a “reward” for working in more remote areas was generally supported. Among many, there was a sense that any economic advantage to working in rural areas was being eroded.

Options:

Sabbatical arrangements. Many physician and non-physician participants viewed sabbaticals as an “excellent” or “brilliant” option. This solution seemed to offer both financial (if the Province contributed some funds) and lifestyle incentives. A potential ‘downside’ also was identified, in that some physicians may choose not to return after their sabbatical.

The concept involves:

- Minimum length of service for involvement is established – e.g. seven years in one location.
- Physician banks some percentage of gross income, pre-determined according to planned length of absence.
- The Province adds some amount – perhaps variable depending on location, with a higher contribution for more remote areas
- Physician takes time off (up to one year) for individual purpose – travel, education, skills upgrading, etc.
- Physician’s replacement is arranged centrally through such program as the Rural Locum Program.

Remote incentive. Most participants agreed that some incentive was deserved for clearly identified “remote” areas. Most were open to a range of possibilities:

- Lump sum bonus
- Financial assistance for occasional ‘trips out’ with family
- Increase on fee-for-service after pre-determined number of years
- Increased financial assistance toward sabbatical
- Assistance for educational absences

Long service financial incentive. Some support was received for financial incentive for longer-term stays in all rural areas. Options included:

- Retention bonus after, for example, five and 10 years of service (British Columbia and Saskatchewan have such agreements).
- Percentage increases in fee-for-service after specified number of years (Quebec has such an agreement).
- One-time bonus, whether cash payment or with an educational link such as educational stipend or contribution toward computer package, for example.
- Annual paid CME for all rural physicians (perhaps after some length of time), such as in Ontario with \$5,000/physician.

A-2. Develop community-building processes among physicians to make practice more collegial and less onerous.

Many suggestions related to the concept of building “communities” of physicians who work together. This could reduce the on-call burden and professional isolation while providing an opportunity to enhance skills. Examples included three 2-physician communities who joined together to share on-call; physicians in a practice who share rather than ‘own’ patients; and the idea of physicians within a community each developing a special skill, such as geriatric or exercise stress testing, to “minimize referrals outside the community and add prestige.” One participant recognized that “so much of it comes down to intangibles – relationships.”

Options/Concept:

- Encourage a co-operative environment among physicians; provide practice and collegial support to bring people together.
 - Communication about ‘success stories’
 - Encourage new physicians to buy into local practices (and existing physicians to provide such an opportunity) rather than overhead payment methods
 - Find innovative ways for 1 and 2-physician communities to collaborate with others
- RPAP’s newly approved Rural Physician Consultant position could provide such services.
- Develop more regional collegiality, through such things as even a once-yearly regional professional/social get-together that includes physicians and spouses.

- Encourage development of special interests/skills among physicians, resulting in a community of physicians, each with a different special skill. (Could tie in with sabbaticals, skills brokering, etc.)

A-3. Investigate innovative ways to increase the critical mass of physicians and develop other system-wide change to enhance care and reduce workloads.

Recommendation A-2 is one way to move toward the achievement of this end. Some people feel there is a need for deeper change in how things are done. For example, how can three physicians be supported where the daily workload only calls for two?

Options:

- Develop new roles and licensing possibilities for IMG physicians who are not currently granted license to practice.
- Encourage use of other professionals to lessen physicians' workloads
- Develop more regional 'team' approaches.
- Encourage or make more available the use of alternative payment mechanisms.

Possible method of development:

- Convene a group of innovative yet practical thinkers to build a 'framework' of a new system. (See C-6).

A-4. RPAP should reinforce to the Minister of Health and Wellness and the rural RHAs the need for adequate medical infrastructure and supporting resources.

Participants regularly mentioned the lack of or "gradual attrition" of adequate supports in rural areas to provide quality care. Retention of well-trained nurses was the most frequently mentioned concern. Problems with the whole support system – technology, personnel and hospital staff – also were highlighted.

Options:

- RPAP draws AH&W and RHA attention to the issue through letters and presentations to the Minister, Standing Policy Committee on Health and Safe Communities, and RHA CEOs and Chairs.
- Initiate discussions for development of a rural health plan to extend beyond a rural physician action plan. (See C-6).

A-5. Develop easier access to specialists.

Many participants raised issues related to access to specialists, while others indicated they had no problems. Many issues focused on the need for occasional face-to-face contact with specialists to enhance mutual understanding. The

Capital Health 24-hour trauma line that provides access to specialists was mentioned as helpful.

Options:

- Have more clinics by specialists in smaller areas. Provides opportunity to meet the rural physicians and get to know each other and their issues. “This would help us to feel attached, connected.”
- Secure funding (perhaps semi-annual) to help specialists visit rural areas. They could provide input to such things as monitoring systems and protocols on such visits.
- Pay specialists’ travel expenses for their visits to rural areas (travel time is currently paid but not expenses).

A-6. Encourage RHAs to involve physicians more in health care planning.

Some physicians wanted help in their efforts to have more input on services needed within the community. Others felt physicians should have more opportunity for input into the planning and operation of programs and facilities both within their communities and that they use as province-wide services. This was intended to build a “sense of worth and value” while also improving the health care system.

Options:

- The RPAP should work directly with and establish working relationships with relevant RHA staff and board members. RHAs (where needed) could be encouraged to show more appreciation for and interest in their physicians.
- The RPAP Rural Physician Consultant position could be one of the main venues for learning of situations where particular influence is required.
- Members of the RPAP Co-ordinating Committee or the Program Manager could provide assistance, as appropriate.
- The Physician and Family Support Program could provide training/facilitation for physicians wanting to learn how to become more involved and influential in such situations.

A-7. Develop standard contracts for use with new physicians in particular.

(Suggested revision March 5 to eliminate “standard contracts” and recommend guidelines instead.)

Some concern was expressed about new physicians, particularly IMGs, being unfairly treated through contracts with RHAs and existing physicians. While one physician suggested the need for a standard 30-70% split for overhead, another suggested that 30% is often a “rip-off.”

Options:

- Develop standard contracts and determine ways they can be encouraged or enforced.

- Provide mediation services (e.g. RPAP contracting with the Physician and Family Support Program) when there is an existing conflict.
- Provide business management assistance, perhaps through the services of MD Management.

A-8. Increase opportunities for retraining

There was some feeling that the RPAP skills enhancement programs (Additional Skills Training and Enrichment) help, but need to expand to include more flexibility.

Options:

- Provide support for retraining, whether clinical, public health or administrative.
- Include funding for accommodations and living expenses while away from home.

A-9. Provide recognition for special skills.

An evaluation of the rural on-call remuneration program, currently under way through RPAP, will likely provide recommendations relating to GPs with special skills and retention.

Options:

- Build any relevant results of the rural on-call remuneration program evaluation into the RPAP rural physician retention plan.

A-10. The RPAP should encourage improvements in rural CME.

Two opposite ends of the spectrum were presented through participants' comments: for some, a desire for more close-to-home CME and, for others, more effort to make CME a combined educational/social get-away for the physician and spouse. (The current RPAP evaluation of CME programs for rural physicians may provide more detailed insight on this issue.)

Options:

- Provide more CME in smaller areas, through visiting specialists etc.
- If CME is in a regional centre, provide it on a weekend rather than weekday.
- Develop CME into more 'weekend packages' in, for example, Edmonton or Jasper. Include educational and recreational activities.
- Encourage family members to attend.
- The RPAP to encourage CME to investigate this issue further and develop appropriate solutions.

A-11. Promote a more concerted effort to provide and use Telehealth.

There was strong feeling among some participants (particularly academic) that Telehealth needs to be strengthened, while others did not agree. (There may be other evaluations or investigations relevant to this issue?)

Options:

- Create a consortium of the RPAP, academics and government to develop a more concerted plan to expand availability and use of Telehealth. Some possibilities include:
 - Invest the time and resources to make it work.
 - Provide sufficient opportunity for physicians to become comfortable with using it through training; support through the Rural Locum Program.
 - Engage local champions and visiting experts to build momentum.
 - Provide wider access, beyond more remote areas.

A-12. Continue to develop and support efforts to promote rural practice as a viable option and to prepare new physicians for it.

Participants supported the RPAP's current efforts in medical education and rural recruitment to train and select physicians for rural practice. Most strongly agreed that keeping rural physicians was very dependent on selecting those with the right skills, attitudes and inner resources to handle and even enjoy it.

Options:

- Increase attention to preparation for 'small town life,' both in medical school and for current physicians, through training on such issues as personal boundaries.

A-13. Consider initiatives that may be of particular relevance to retention of IMGs.

A number of comments related to the needs of new internationally trained physicians. A study is currently under way on IMGs and is expected to include some information related to retention.

Options:

- Integrate relevant recommendations from the IMG study into the RPAP rural physician retention plan.
- Further investigate the suggestion that the College of Physicians and Surgeons could develop more culturally sensitive means of initiating investigations with IMGs (i.e. personal contact or 'softer' form letter).

B. FAMILY/LIFESTYLE

Recommendations:

B-1. Increase support for spouses of physicians, in particular through localized area support networks organized by the Rural Physician Spousal Network.

Most participants acknowledged the importance of happy spouses to the satisfaction and retention of rural physicians. Many participants were aware of the Rural Physician Spousal Network, an RPAP initiative, and saw it as a good start but needing “more horsepower” and continued growth.

Options:

- Facilitate development of area support networks. Support networks, organized and led by local spouses through the Rural Physician Spousal Network, were seen as a way of getting more spouses involved and providing concrete and meaningful peer support. The networks could be developed through:
 - Leadership by a specific spouse for each area
 - Gathering of volunteers to form a telephone network
 - Organization of meetings for each area, with agenda and style to suit local needs.

The Rural Physician Spousal Network has already set a goal for 2001-2 of holding three regional meetings (north, south, central).

- Combine spousal get-togethers with CME whenever possible, as an additional opportunity for spouses to meet within a region or provincially.
- Continue to provide spousal get-togethers at existing conferences.

B-2. Enhance the RPAP’s collaboration with the AMA’s Physician and Family Support Program.

Many participants regarded the PFSP as a very useful service. They tended to view it as a program for those in crisis rather than with a preventive focus. The PFSP itself considered that it could collaborate with and provide required services to the RPAP.

Options:

- The RPAP could engage the PFSP as a service provider for stress/balance/isolation materials, counselling and workshops specifically targeted for rural physicians and their families. The focus would be on preventive self-help measures to living and prospering in rural communities; providing tools to help physicians and families take responsibility for their own happiness.
- The RPAP could use the PFSP’s expertise in mediation and facilitating win-win resolutions for RHA, community and physician-physician disputes.

- The RPAP could provide rural-specific feedback and suggestions to the PFSP for its programming (including whether specific programming is required for new IMGs).
- The RPAP could promote increased awareness of the PFSP’s services among rural physicians and their families.

B-3. Expand the Rural Locum Program to provide increased opportunity for much-needed breaks for rural physicians.

Participants described the RLP as one of the RPAP’s best known and most appreciated programs. At the same time, suggestions for continued improvement were made. It is recognized that the availability of locums is a determining factor for any changes.

Options:

- Lengthen the eligible time off, recognizing that physicians working in these settings need more than 4 weeks off a year. Strive for 6 weeks of vacation and 2-4 weeks for CME activities a year.
- Expand the weekend program to include communities with fewer than five physicians (rather than fewer than 4).
- Decrease the eligible age for the senior program to 50 years (from current 60 with possibility for 55).

B-4. Organize a comprehensive orientation program for new rural physicians.

Some participants suggested that an improved orientation process for new physicians, particularly IMGs but similar may apply to Alberta graduates, would ease integration of the physician and family into the medical community and community-at-large. It may also be useful to consider what the needs are now for physicians who came to Alberta one or two years ago; a study of IMGs and retention-type issues, supported by the RPAP and to be released soon, will likely provide some guidance. “We need to help IMGs integrate and bridge into the mainstream.”

Options:

- Organize in collaboration with communities, RHAs and local physicians a personal approach to greeting and assisting new physicians. For example, ensure someone greets them at the airport, takes them to the College of Physicians and Surgeons to initiate processes there, provide banking and other information.
- Prepare a booklet of information to orient physicians and their families to such things as day care centres, banks, housing prices, schooling, educational options, moving companies, etc. Provide as much information as possible before they arrive.
- Pair each new physicians with an experienced physician of similar background in another community to act as mentor and confidante.

- Ask the RPSN to build a ‘library’ of suggestions for different audiences: how to overcome the problems of adjusting for the physician and spouse, and how to welcome newcomers for communities and RHAs.

B-5. Provide whatever assistance is feasible to help spouses find meaningful employment.

Participants recognized that spousal employment is a significant issue – but a difficult one to influence. Most spouses interviewed did not expect or want intervention on their behalf. They saw this as a factor that ‘came with the territory’ and that families would have to deal with in their own ways. One spouse noted, “We have found that as a rural anaesthetist and providing obstetrical coverage, it is not enough for the spouse to have opportunity. Outside home interests, work etc. is continually sabotaged by physician’s after-hours work demands. Some physicians suggested ways of providing assistance.

Options:

- At time of recruitment, encourage the region/community/other physicians to use their influence to meet the spouse’s needs.
- The RPAP should talk with unions about how their policies could influence spousal employment.
- The RPAP, in collaboration with the community, could provide guidance on options available, such as volunteer work, distance education, etc.

B-6. Determine what assistance the RPAP could give toward improving educational standards for children.

Education for children was often mentioned as a significant issue that leads many physicians to leave rural areas. Most participants saw this as a societal issue, not a physician-specific issue. Few felt there the RPAP could prompt any significant change. “Our ability to influence this is ‘almost zero.’” Others saw it as a personal responsibility – “You have to help them (the children) yourself.”

Options:

- Provide funding to help send children of rural physicians to distant schools. (The alternate view was this was not a ‘money issue’ and that those who want to keep their families together will move when the children reach a certain age.)
- The RPAP could write to Alberta Learning, expressing concerns and emphasizing the need for improved educational opportunities for all rural Albertans and pressing for changes (such as shortened classes).
- The RPAP should “look at things that are positive and possible” and communicate through newsletters and on the website about options and examples of what has worked well for some physicians, for example home schooling, distance education, links with other organizations, computer camps, etc.

B-7. Explore the possibility of a sabbatical program for rural physicians.

See A-1. “We need to explore more fully the idea of a sabbatical; personally I find that I reach a point about every 7 years where I am feeling fed-up with my dead-end job, unappreciated and underpaid etc. If one could take three months off – paid, and with a back-up in place, one would return refreshed; it could address many of the problems of burn-out, addiction, family breakdown, etc.”

C. COMMUNITY

Recommendations:

C-1. Establish links with RHA Community Health Councils (or other appropriate community groups) to involve them in recruitment/retention issues.

Many participants recognized the difficulty of getting communities involved with physician issues. Some suggested the CHCs as a viable means of achieving community involvement. Others suggested, “Communities recognize the value of having physicians, whereas the government does not recognize the importance of rural physicians.”

Options/Concept:

- Meet with Community Health Councils to inform them about the RPAP and the importance of retaining rural physicians to their communities. Involve them when specific circumstances arise.
- Work to establish working relationships among CHCs, RHAs, other involved community groups and physicians.
- Involve CHCs in orientation programs for rural physicians.
- Inform the CHCs, and other important community linkages, about steps they can take to keep physicians (which would vary by community but could include anything from owning the medical clinic to organizing a community welcoming/orientation get-together for a new physician to inviting the spouse to a recreational activity.)
- Inform the CHCs and encourage them to provide the social support structures needed by spouses, i.e. help with childcare, friendships, and social outlets.
- The new RPAP Rural Physician Consultant position could facilitate such initiatives.

C-2. Involve the community in welcoming and orientation of new physicians.

See B-4.

C-3. Encourage rural communities (perhaps through the RHA Community Health Councils) to develop physician retention plans.

Many participants saw the importance of involving the community in developing ways to ease physicians and their families into and keep them content within the community. This is essentially assisting communities with marketing, which starts at recruitment and continues into retention.

Options:

- Encourage communities to be flexible to meet a physician’s needs and find ways to deepen a physician’s commitment to the community. Examples of ways to help include providing interest-free loan or subsidized mortgage to

provide an incentive to build a house, contract to buy-back a home if the physician leaves after five years, etc.

- Help communities recognize ways of maintaining ongoing interest in and support for the medical community, such as by providing weekends away, involving the spouse, etc. (See C-1).

C-4. Work individually with communities with high physician turnover.

Some specific work with communities with high physician turnover or known difficulties may be productive.

Options:

- The RPAP, as a facilitator for recruitment and retention initiatives, could identify such communities and involve ‘all the players’ to gain insight into the core issues.
- The PFSP could, when appropriate, facilitate discussions to identify issues and develop lasting solutions.

C-5. Increase community education and action on the vital nature of their medical community, and the importance of preserving and nurturing it.

A few participants emphasized the importance of community education – and of going beyond awareness and understanding to action. Examples included developing more realistic public expectations of the health care system and physician services, and education (often at grade school level, which then takes it home) about such things as wise use of antibiotics.

Options:

- The RPAP could form a multi-stakeholder group to examine rural community education needs, to explore opportunities where education could reduce physician workload and improve the community, etc. The result could be an action plan that could be implemented province-wide and/or tailored to individual communities. Local community involvement, through CHCs and perhaps with involvement of physician spouses, would be essential for effective implementation and concrete results.

C-6. Foster discussions that could lead to development of a community health care approach in rural areas, or a ‘rural health plan’ rather than a ‘rural physician plan.’

The importance of the total medical infrastructure, and other health care professionals, to rural physicians’ ability to provide quality care, was often emphasized (see A-4). Some participants thought that future-oriented consideration of services that would help rural communities as a whole, and help physicians at the same time, could be beneficial – such as dietary, wellness,

counselling services. Encouragement of physicians to partner and help more preventive/wellness activities happen in their communities also was suggested.

Options:

- The RPAP could initiate discussions with representative individuals and organizations. The objective would be to bring forward new approaches that could lead to improved health care in rural Alberta. (See A-3).

D. OTHER

D-1. Communication

Suggestions about the RPAP's communication with its many audiences emerged from the retention discussions.

Options:

- Communicate about what works well, through newsletters, web site, manuals and face-to-face. For example, the RPAP could regularly highlight:
 - ways that physicians are working together to reduce on-call and provide quality care
 - people's successes in dealing with their children's educational challenges
 - how physicians and their families have gotten involved in their communities
 - what some RHAs and communities are doing to involve and integrate their physicians
- Increase community education and foster community action to preserve and nurture rural health care.
- Call for and help initiate more public education about wise use of health care resources etc.
- Establish relationships at all levels (RHAs, physicians, Regional Medical Directors, Community Health Councils, other health care providers etc.), to enhance understanding of physicians' issues and lead toward ongoing productive solutions.
- Provide positive affirmations to physicians that "Yes, you are important. You are needed and appreciated." Show through examples.
- Involve physicians and other audiences in continually assessing and updating the retention plan. Small groups could work on specific projects. Accomplishments and updates should be provided regularly through ongoing RPAP communication vehicles, including face-to-face.

D-2. Research

The need for specific research into retention issues was highlighted by some participants, and was obvious through a review of the literature.

Options:

- The RPAP should support coordinated and disciplined research on the key factors for retention of physicians in rural practice settings. The research should be led by RPAP and contracted out (e.g. through the Alberta Family Practice Research Network).

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