

**EVALUATION OF THE RPAP
ADDITIONAL SKILLS TRAINING PROGRAM
AND
THE ENRICHMENT PROGRAM**

Prepared For:

RURAL PHYSICIAN ACTION PLAN COORDINATING COMMITTEE

Submitted By:

RPM PLANNING ASSOCIATES LIMITED

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We would like to express our gratitude for the insights we received from representatives from the Faculties of Medicine at the University of Calgary and the University of Alberta during the evaluation. The information provided insights of past directions and future possibilities.

We appreciated the insights we obtained from selected Regional Health Authorities, as well as the College of Physicians and Surgeons of Alberta, and the Alberta Medical Association. The information assisted us in identifying some of the key environmental factors and understanding how they affect various aspects of the Enrichment Program and Additional Skills Training Program.

We are grateful for the assistance of Mr. David Kay—Program Manger of RPAP for facilitating the collection of the data and helping us think through some of the critical issues.

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this Evaluation Report is to present our key findings, conclusions, and recommendations to the Rural Physician Action Plan Coordinating Committee respecting the effectiveness of the RPAP Enrichment Program and the Additional Skills Training Program.

BACKGROUND

The Government of Alberta established Alberta's Rural Physician Action Plan (RPAP) in early 1991, as a comprehensive action plan for the recruitment and retention of rural physicians. Since the Plan's inception, over one dozen initiatives, some medium and others long term in nature, have been implemented "on the basis of influencing physicians' decisions about moving to and remaining in a rural Alberta community". The Plan strives to address the professional and lifestyle issues that influence physician recruitment and retention.

The RPAP focuses its initiatives on three distinct target groups: physicians currently in rural practice, medical students and Residents, and rural RHAs and their partner communities. Currently, there are over one dozen initiatives, including the Enrichment Program, and the third year Additional Skills Training Program for Residents.

The **Enrichment Program** provides assistance to practicing rural physicians wishing to upgrade existing skills or learn new ones. These skills must be necessary to improve the level of health services in the community or region, or to replace existing skills that will be lost due to retirement or other reasons.

There are a total of 24 **Additional Skills Training (AST)** positions currently available to Residents interested in rural practice. The objective is to give the trainees additional skills needed in a rural practice setting (e.g. anaesthesia, general surgery, obstetrics, emergency medicine, care of the elderly) and which are beyond the skills which the average rural physician equipped with a two year residency could reasonably be expected to have acquired.

EVALUATION OBJECTIVES AND METHODOLOGY

The Terms of Reference specified the following objectives for the evaluation:

- Evaluate the extent to which these programs are meeting their stated objectives and the goals of the RPAP (i.e. aid rural physician recruitment and retention).
- Assess stakeholder participation and satisfaction with the Additional Skills Training and Enrichment Programs.
- Assess the extent to which the return-in-service commitment (RiSA) facilitates or hinders the Additional Skills Training Program.
- Examine the candidate selection process for the Additional Skills Training program, and the application process for the Enrichment Program and assess whether these processes facilitate or hinder the programs.
- Evaluate the extent to which the two programs result in the physicians delivering needed medical services, particularly concerning:
 - (a) the responsiveness of RHAs to provide the necessary resources for Additional Skills and Enrichment Program trainees to practice the skills acquired;
 - (b) the extent to which the two programs meet a need for physicians with additional skills/competencies within the RHA, including whether the two programs are of sufficient flexible duration; and
 - (c) the adequacy of honorarium payments for the Enrichment program, and the ability/desirability to perform FFS services unrelated to Enrichment training and outside of training times.

RPM personnel obtained information from the following sources to address the evaluation objectives:

- relevant documents such as the RPAP Business Plan, the Additional Skills Training Working Group and the Additional Skills Implementation Plan Reports, and relevant correspondence from the from various stakeholders—e.g., College of Family Physicians of Canada (CFPC), University of Alberta (U of A), University of Calgary (U of C), College of Physicians and Surgeons of Alberta (CPSA), RPAP Coordinating Committee;
- program statistics such as the number of physicians applying for the Enrichment Program and the number of practitioners whose applications are/not accepted, the number of Residents who apply to the AST Program and are/not accepted, and the number of Return-in-Service Agreements (RiSA) and the locations of these RiSAs;
- interviews with 18 of 68 (27%) participating physicians undergoing or who have completed training through the Enrichment Program any time since the inception of the program in 1991 and 1999 [Note: Our original sample was 28 of 68 physicians—41%. However, several individuals chose not to participate and even after replacement physicians were selected, only 18 individuals agreed to an interview].

- interviews with 13 of 78 (17%) participating physicians undergoing or who have completed training through the Additional Skills Training Program any time between 1993 and 1999 [Note: Our original sample was 27 of 78 physicians—36%. However, several individuals chose not to participate and even after replacement physicians were selected, only 13 individuals agreed to an interview].
- interviews with individuals from the Faculty of Medicine staff at both Universities involved in both programs, representatives from the RHAs, representatives from the RPAP Coordinating Committee, members of the Council of Medical Directors, individuals from Alberta Health and Wellness, representatives from the Alberta Medical Association, as well as the College of Physicians and Surgeons of Alberta; and
- interviews with other stakeholders that seem to be appropriate such as instructors, not part of the Faculty of Medicine at U of A/U of C, who have provided training to practicing physicians through the Enrichment Program.

There are three limitations of the evaluation of the Enrichment Program and the Additional Skills Training Program. None of these limitations compromises the value of the evaluation or our ability to address any of the objectives specified in the Terms of Reference.

First, the evaluation was confined to published expectations, objectives, and processes because of budget and time limitations.

Second, we did not interview a representative random sample of graduates of the AST Program or practicing physicians who accessed training through the Enrichment Program. Rather we chose our sample using ‘purposive sampling’ which is a non-probability sampling technique. The evaluator purposively chooses participants for the sample, based on specific a priori criteria, to capture and describe the central themes or principal outcomes that cut across a great deal of participant or program variation. To appropriately evaluate both the Enrichment Program and the Additional Skills Training Program, we applied the following criteria in selecting our sample of physicians:

- the physician is currently practicing or had practiced in a rural community;
- the physician obtained additional skills training in one of a number of practice areas such as obstetrics, anaesthesia, palliative care, or emergency medicine; and
- varied lengths of training—i.e., some physicians who completed training in 2 weeks, and others who finished their training in several months.

Third, we were unable to find information to help us locate disgruntled prospective Enrichment applicants who did not bother to pursue formal applications. Accordingly, we could not determine the barriers these individuals faced when applying to the Enrichment Program. While this may have provided us with some insights about possible changes that ought to be made to the Enrichment Program, we did obtain this type of information from other stakeholders.

**FINDINGS
AND
CONCLUSIONS**

EVALUATION QUESTIONS	FINDINGS AND CONCLUSIONS
<ul style="list-style-type: none"> To what extent are the Additional Skills Training Program and the Enrichment Program meeting their stated objectives and the goals of the RPAP (i.e. aid rural physician recruitment and retention)? 	<p>All but one of the 18 physicians we interviewed stated the Enrichment Program <i>does</i> help to retain rural physicians. However, these physicians were evenly split regarding whether the Enrichment Program helps to recruit rural physicians.</p> <p>The Enrichment Program does facilitate the acquisition of additional competencies and upgrading existing skills, which helps a physician feel more confident and comfortable in performing specific procedures. Moreover, 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.</p> <p>Most of the 13 Additional Skills Training graduates believe the AST Program <i>does</i> help to recruit, as well as to retain rural physicians [9 of 13—69%, and 10 of 13—77%].</p> <p>Physicians who attended the Additional Skills Training Program have obtained additional skills needed for a rural practice setting (e.g. anaesthesia, general surgery, obstetrics) and which are beyond the skills, which the average rural physician equipped with a two year residency, could reasonably be expected to have acquired. These physicians believe that the AST Program equips the individual with an appropriate level of competence and skill, which makes the physician more comfortable in his/her ability to meet the needs of the community.</p>

EVALUATION QUESTIONS	FINDINGS AND CONCLUSIONS
<ul style="list-style-type: none"> To what extent do Residents and physicians participate in, and how satisfied are they with, the Additional Skills Training and Enrichment Programs? 	<p>Between 1994/95 and 99/2000, 68 practicing physicians obtained training through the Enrichment Program—an average of 11 physicians annually. Almost all of the physicians we interviewed who received training through the Enrichment Program indicated they were ‘satisfied’ with the quality of the instruction from the preceptor(s) primarily because the preceptor(s) was willing to teach, and inclined to let the physician do a lot of the work.</p> <p>Most of the physicians we interviewed who received training through the Enrichment Program were satisfied with the support provided by the RHA [10—‘very satisfied’, 4 ‘somewhat satisfied’]. Only one physician indicated he was ‘dissatisfied’ with the support from the RHA, while one individual was neutral about the support, and 3 other physicians stated they took their training through the Enrichment Program prior to regionalization.</p> <p>On average, only 46% of the 24 FTEs [11 of 24 FTEs] were filled in each of the fiscal years from 1997/98 to 2000/2001, there were 11 FTEs of 24 FTEs enrolled in the Additional Skills Training Program. All but one of the 13 the Additional Skills Training graduates whom we interviewed stated they were ‘very satisfied’ with the quality of the instruction from the preceptors [1 individual was ‘somewhat dissatisfied’]. The following are reasons provided by some of the 12 respondents respecting their satisfaction with the quality of instruction from the preceptors:</p> <ul style="list-style-type: none"> “lots of volume and a good variety of patients on which to practice”; “I was trained by specialists who were willing to have a general practitioner involved in ‘hands-on’ experience in surgery”; “the preceptors at the community hospital site supported a general practitioner learning anaesthesia”.
<ul style="list-style-type: none"> To what extent does the return-in-service commitment (RiSA) facilitate or hinder the Additional Skills Training Program? 	<p>Beginning in 1997/98 RPAP required Residents enrolled in the Additional Skills Training Program to obtain a Return-in Service Agreement (RiSA). However, only 3 of the 13 AST graduates whom we interviewed had been enrolled in the Additional Skills Training Program since the RiSA became a requirement and, each of these individuals had a Return-in Service Agreement (RiSA).</p> <p>The Return-in-Service Agreement may negatively affect an individual’s decision about applying to the Additional Skills Training Program. However, its influence is far less significant than such factors as the ‘debt-load’ of the applicant, RHA recruitment practices, and family influences.</p>

EVALUATION QUESTIONS	FINDINGS AND CONCLUSIONS
<ul style="list-style-type: none"> To what extent does the candidate selection process for the Additional Skills Training Program, and the application process for the Enrichment Program facilitate or hinder the programs? 	<p>Many of the steps in the Enrichment Program application process are invisible to the applicant. Fifteen of the 18 physicians we interviewed indicated they were 'satisfied' with the application process [11 of 18 'very satisfied', 4 'somewhat satisfied'], while one individual stated he was 'very dissatisfied' with the application process, and two other physicians indicated it was 'not applicable'.</p> <p>The individual who indicated he was 'very dissatisfied' with the application process stated that "the University of Calgary stonewalled the process in arranging for a preceptor because there was resistance about teaching a general practitioner how to perform caesarian sections."</p> <p>Even those physicians who stated they were 'satisfied' with the application process noted it was "unclear who should be contacted" and the "communication during the application process was almost non-existent."</p> <p>During our interviews with the 18 physicians we asked about the elapsed time between submitting an application for training through the Enrichment Program and receiving approval. Although the data indicate that the average elapsed time was 3 months, one physician waited 8 months to receive approval of his training request, while another waited 5 months.</p> <p>Notwithstanding that the physicians are waiting a lengthy period of time before their application for training through the Enrichment Program is approved, 15 of 18 physicians [83%] indicated this length of time 'was about right'.</p> <p>Most of the 18 physicians [15 of 18—83%] stated the length of time between approval for training and commencing the training was 'about right'—primarily because it takes the physicians time to organize his/her personal affairs. It is expected that, in the future, the Skills Broker will be able to reduce this waiting time—particularly with respect to making arrangement with specific preceptors to provide the training.</p> <p>All of the Additional Skills Training graduates we interviewed were satisfied with the application process. Although the individuals indicated the application was straightforward, it took an average of 3 months between submission of the application and receiving approval. Most of the 13 AST graduates noted the elapsed time was 'about right', while 2 stated it was 'too long'. The AST graduates did suggest, however, that the waiting time should be reduced to facilitate Residents making plans.</p>

EVALUATION QUESTIONS	FINDINGS AND CONCLUSIONS
<ul style="list-style-type: none"> To what extent are the RHAs responsive in providing the necessary resources for Additional Skills and Enrichment Program trainees to practice the skills acquired? 	<p>We asked the 18 physicians who have received funding for training through the Enrichment Program, if they had discussed their plans with the Regional Health Authority. Most of the physicians noted they had discussed their plans with the RHA [15 of 18—83%].</p> <p>In most cases, the discussions focused on the community need in relation to the training, and obtaining a letter of support from the Regional Health Authority. However, most physicians noted that no supplementary resources (nursing or equipment) were required to support the use of their additional competencies.</p> <p>Only a small number of physicians [5 of 18] spoke to the RHA about the need for nursing and/or equipment required to support the additional competencies.</p> <p>In two cases, for example, the physicians had applied for funding through the Enrichment Program for training in epidurals and discussed with their respective RHAs the need for 'epidural kits' and access to nurses with the appropriate training. Another physician noted he discussed the need for the RHA to develop a multidisciplinary team of 'nursing consultants' to support a palliative care program.</p> <p>Most of the physicians [14 of 18—78%] were satisfied with the support provided by the RHA [10—'very satisfied', 4 'somewhat satisfied']. Only one physician indicated he was 'dissatisfied' with the support from the RHA, while one individual was neutral about the support, and 3 other physicians stated they took their training through the Enrichment Program prior to regionalization.</p>

EVALUATION QUESTIONS	FINDINGS AND CONCLUSIONS
<ul style="list-style-type: none"> To what extent are the two programs of sufficient flexibility and duration? 	<p>The 18 physicians we interviewed about the Enrichment Program had mixed views about whether training for practicing physicians should be offered in short or long time blocks. Specifically, 8 of 18 physicians [44%] indicated it is better to provide training to practicing physicians in short time blocks.</p> <p>The rationale for obtaining training in short time blocks is best exemplified by one physician who stated, “it is almost impossible to take a substantial amount of time away from your practice.” However, 10 of the 18 physicians we interviewed [56%] noted that the length of the training should relate to the training objectives and the procedures the physician wants to learn. Their point of view is best exemplified by one physician who stated, “to learn some types of procedures you need to be immersed in the training for a longer period of time.”</p> <p>Currently the Additional Skills Training Program offers training in 6 and 12 month blocks. Stakeholders indicated this is the minimum time required to appropriately train Residents in specific skills designed to meet the distinct needs of rural communities.</p>
<ul style="list-style-type: none"> To what extent are the honorarium payments for the Enrichment Program adequate, and the ability/desirability to perform FFS services unrelated to Enrichment training and outside of training times? 	<p>Physicians accepted in the Enrichment Program receive an honorarium of \$76,000 per year, prorated for the length of training.</p> <p>Sixteen of the 18 physicians we interviewed received an honorarium through the Enrichment Program. On average, the physicians received the honorarium 6 weeks after commencing the training. Most of the physicians indicated this was ‘about right’ [10 of 16—63%], while 6 of the 18 physicians noted it “took too long to receive the honorarium”. Only 1 of the 18 physicians we interviewed indicated that the honorarium received through the Enrichment Program covered <i>both</i> expenses and lost income.</p> <p>In all cases, the physician’s lost income was <i>not</i> covered by the honorarium received through the Enrichment Program, and in two cases the honorarium did not cover the physicians’ expenses. On average, physicians lost \$30,000 in income during the time they were receiving training through the Enrichment Program [Note: The amount of lost income ranged from \$6,0000 to \$80,000, which depended on the length of the training].</p>

POINTS TO PONDER

A. Degree of Congruence Between the Objectives of the Additional Skills Training Program and the Current Course Offerings

The Additional Skills Training Program can be viewed within the spectrum of medical education. For example, at the University of Alberta, an undergraduate rotation in family medicine became mandatory in 1997. In addition, there is a 4-week mandatory Rural Family Medicine clinical rotation, which provides exposure to the challenges and opportunities of rural family practice in Alberta. Moreover, at the University of Alberta Family Medicine Residency Program, opportunities for rural experience come in the residents' second year, where residents can do either 4, 16 or 20 weeks of family medicine in one of 10 rural residency training locations.

Residents are exposed to the challenges faced by rural physicians and the required skills to meet community needs. The Additional Skills Training Program offers further training to residents in the following areas: anaesthesia, obstetrics, surgery, sports medicine, geriatric medicine, palliative care, and emergency medicine [CFPC—EM]. Some of these programs may be offered in combination with each other—such as surgery/obstetrics, obstetrics/emergency, and care of the elderly/palliative care.

Since most of the AST graduates in emergency medicine, and care of the elderly/palliative care work in urban communities, there is a lack of congruence between the objectives of the Additional Skills Training Program and some of the course offerings. This issue needs to be examined by the RPAP Coordinating Committee. In addition, the RPAP Coordinating Committee should identify the relationship between the Additional Skills Training Program and the new core postgraduate curriculum for rural family practice and the rural family medicine stream—the Alberta Rural Family Medicine Network.

B. Determining Standards for Training

The RPAP Coordinating Committee should take a leadership role of involving stakeholders—including the CPSA, through a transparent process, to develop standards for training. Developing these standards should lead to a consistency of training for rural general practitioners, in order that they can attain additional competencies.

C. Increasing the Role of the Regional Health Authorities in Promoting the Additional Skills Training Program and the Enrichment Program

Regional Health Authorities are responsible for developing physician manpower objectives and ensuring there are the right physician resources in the right locations to meet community needs. Both the Additional Skills Training Program and the Enrichment Program can assist the RHAs in meeting these responsibilities. Accordingly, the RPAP Coordinating Committee should work with each of the rural Regional Health Authorities to ensure they are promoting both the AST and Enrichment Programs within the context of their physician resource needs.

D. Providing Training Through the Enrichment Program in Small Time Blocks

Providing training to practicing physicians in short time blocks acknowledges the difficulties they and their colleagues face when the individual is away from the community for an extended period of time. Some stakeholders made a compelling argument that practicing physicians are skilled practitioners with several years experience and, therefore, they do not require as much time as Residents to learn new procedures or upgrade existing skills. Others countered that learning certain procedures requires the physician to be immersed in training for a long block of time. These individuals asserted that breaking a large block of time into small portions, spread over a long period, only dilutes the intensity of the training experience—thereby weakening the very skills that the physician wanted to strengthen.

E. Locum Coverage for Practicing Physicians In Order to Obtain Training Through the Enrichment Program

The RPAP Coordinating Committee should attempt to identify options respecting coverage to practicing physicians who want to obtain training through the Enrichment Program—particularly when the training requires the physician to be away from his/her practice of longer than 3 months. If RPAP can provide realistic options for physicians to obtain coverage while they are receiving training through the Enrichment Program, these options could be included in the promotion of the program. This could help to encourage a greater number of physicians in applying for funding through the Enrichment Program, because it removes an potential barrier to the physicians taking time from their practice to either upgrade their skills or acquire new skills.

F. Identifying Preceptors to Provide Training to Practicing Rural Physicians Through the Enrichment Program

To ensure that practicing rural physicians can access training through the Enrichment Program quickly requires the availability of preceptors who have the time and the interest in: (1) preparing appropriate educational materials to meet the specified training objectives; and (2) teaching, observing, and evaluating the physicians receiving Enrichment Training. In addition, these preceptors need to have ready access to patient material, in sufficient volume, to be able to teach the practicing physician what he/she wants to learn and what the preceptor believes the physician needs to know in order to perform the procedure safely for **both** routine and complex cases.

Stakeholders indicated that there is a shortage of physicians willing to assume the role of preceptor. They cite the following reasons for this lack of interest:

- There is a lack of physicians in some specialties and, therefore, potential preceptors for the Enrichment Program would prefer to invest their time in teaching 4th-Year Residents in their own specialty.
- Specialists are already carrying a large load—teaching and patient care responsibilities.
- There is no honorarium for the preceptors who provide Enrichment Training.

Some stakeholders believe that offering potential preceptors an honorarium would help to entice physicians to provide training to practicing rural physicians, and suggested that an honorarium of approximately \$500 per trainee would be sufficient. The RPAP Additional Skills Technical Working Group recognized this issue in its Implementation Plan of March 2000, and it recommended an honorarium of \$1,000 per trainee month.

**PURPOSE
BACKGROUND
EVALUATION OBJECTIVES
AND
METHODOLOGY**

1.1 PURPOSE

The purpose of this Evaluation Report is to present our key findings, conclusions, and recommendations to the Rural Physician Action Plan Coordinating Committee respecting the effectiveness of the RPAP Enrichment Program and the Additional Skills Training Program.

1.2 BACKGROUND

The Government of Alberta established Alberta's Rural Physician Action Plan (RPAP) in early 1991, as a comprehensive action plan for the recruitment and retention of rural physicians. Since the Plan's inception, over one dozen initiatives, some medium and others long term in nature, have been implemented "on the basis of influencing physicians' decisions about moving to and remaining in a rural Alberta community". The Plan strives to address the professional and lifestyle issues that influence physician recruitment and retention.

The RPAP focuses its initiatives on three distinct target groups: medical students and Residents, physicians currently in rural practice, and rural RHAs and their partner communities. Currently, there are over one dozen initiatives, including the third year additional skills training program for Residents, and the Enrichment Program.

The **Enrichment Program** provides assistance to practicing rural physicians wishing to upgrade existing skills or learn new ones. These skills must be necessary to improve the level of health services in the community or region, or to replace existing skills that will be lost due to retirement or other reasons.

There are a total of 24 **Additional Skills Training (AST)** positions currently available to Residents interested in rural practice. The objective is to give the trainees additional skills needed in a rural practice setting (e.g. anaesthesia, general surgery, obstetrics, emergency medicine, care of the elderly) and which are beyond the skills which the average rural physician equipped with a two year residency could reasonably be expected to have acquired.

1.3 EVALUATION OBJECTIVES AND METHODOLOGY

1.3.1 EVALUATION OBJECTIVES

The Terms of Reference specified the following objectives for the evaluation:

- Evaluate the extent to which these programs are meeting their stated objectives and the goals of the RPAP (i.e. aid rural physician recruitment and retention).
- Assess stakeholder participation and satisfaction with the Additional Skills Training and Enrichment Programs.
- Assess the extent to which the return-in-service commitment (RiSA) facilitates or hinders the Additional Skills Training Program.
- Examine the candidate selection process for the Additional Skills Training program, and the application process for the Enrichment Program and assess whether these processes facilitate or hinder the programs.

- Evaluate the extent to which the two programs result in the physicians delivering needed medical services, particularly concerning:
 - (a) the responsiveness of RHAs to provide the necessary resources for Additional Skills and Enrichment Program trainees to practice the skills acquired;
 - (b) the extent to which the two programs meet a need for physicians with additional skills within the RHA, including whether the two programs are of sufficient flexible duration; and
 - (c) the adequacy of honorarium payments for the Enrichment program, and the ability/desirability to perform FFS services unrelated to Enrichment training and outside of training times.

1.3.2 EVALUATION METHODOLOGY

RPM personnel obtained information from the following sources to address the evaluation objectives:

- relevant documents such as the RPAP Business Plan, the Additional Skills Training Working Group and the Additional Skills Implementation Plan Reports, and relevant correspondence from the from various stakeholders—e.g., College of Family Physicians of Canada (CFPC), University of Alberta (U of A), University of Calgary (U of C), College of Physicians and Surgeons of Alberta (CPSA), RPAP Coordinating Committee;
- program statistics such as the number of physicians applying for the Enrichment Program and the number of practitioners whose applications are/not accepted, the number of Residents who apply to the AST Program and are/not accepted, and the number of Return-in-Service Agreements (RiSA) and the locations of these RiSAs;
- interviews with 18 of 68 (27%) participating physicians undergoing or who have completed training through the Enrichment Program any time since the inception of the program in 1991 and 1999 [Note: Our original sample was 28 of 68 physicians—41%. However, several individuals chose not to participate and even after replacement physicians were selected, only 18 individuals agreed to an interview].
- interviews with 13 of 78 (17%) participating physicians undergoing or who have completed training through the Additional Skills Training Program any time between 1993 and 1999 [Note: Our original sample was 27 of 78 physicians—36%. However, several individuals chose not to participate and even after replacement physicians were selected, only 13 individuals agreed to an interview].
- interviews with individuals from the Faculty of Medicine staff at both Universities involved in both programs, representatives from the RHAs, representatives from the RPAP Coordinating Committee, members of the Council of Medical Directors, individuals from Alberta Health and Wellness, representatives from the Alberta Medical Association, as well as the College of Physicians and Surgeons of Alberta; and
- interviews with other stakeholders that seem to be appropriate such as instructors, not part of the Faculty of Medicine at U of A/U of C, who have provided training to practicing physicians through the Enrichment Program.

1.3.3 LIMITATIONS OF THE EVALUATION

There are three limitations of the evaluation of the Enrichment Program and the Additional Skills Training Program. None of these limitations compromises the value of the evaluation or our ability to address any of the objectives specified in the Terms of Reference.

First, the evaluation was confined to published expectations, objectives, and processes because of budget and time limitations.

Second, we did not interview a representative random sample of graduates of the AST Program or practicing physicians who accessed training through the Enrichment Program. Rather we chose our sample using 'purposive sampling' which is a non-probability sampling technique. The evaluator purposively chooses participants for the sample, based on specific a priori criteria, to capture and describe the central themes or principal outcomes that cut across a great deal of participant or program variation. To appropriately evaluate both the Enrichment Program and the Additional Skills Training Program, we applied the following criteria in selecting our sample of physicians:

- the physician is currently practicing or had practiced in a rural community;
- the physician obtained additional skills training in one of a number of practice areas such as obstetrics, anaesthesia, palliative care, or emergency medicine; and
- varied lengths of training—i.e., some physicians who completed training in 2 weeks, and others who finished their training in several months.

Third, we were unable to find information to help us locate disgruntled prospective Enrichment applicants who did not bother to pursue formal applications. Accordingly, we could not determine the barriers these individuals faced when applying to the Enrichment Program. While this may have provided us with some insights about possible changes that ought to be made to the Enrichment Program, we did obtain this type of information from other stakeholders.

**FINDINGS
AND
CONCLUSIONS**

2.0 INTRODUCTION

This section of the report provides a brief discussion of several environmental factors that affect the delivery of the Additional Skills Training Program and the Enrichment Program. In addition, we present our findings and conclusions respecting each of the objectives for the evaluation.

2.1 ENVIRONMENTAL FACTORS RESPECTING THE ADDITIONAL SKILLS TRAINING PROGRAM AND THE ENRICHMENT PROGRAM

2.1.1 INTRODUCTION: ENVIRONMENTAL FACTORS RESPECTING THE ADDITIONAL SKILLS TRAINING PROGRAM AND ENRICHMENT PROGRAM

As part of evaluating the Additional Skills Training Program [often referred to as the R3 Year] and the Enrichment Program, it is important to acknowledge the influence of the following environmental factors, each of which is discussed in the next several paragraphs:

- a. Health System Restructuring
 - Regionalization
 - Physician Resource Needs
 - Population Increases and Aging
 - Community Needs
- b. Maturing of RPAP as a Program with a variety of initiatives
- c. Role of the University of Alberta and the University of Calgary in training rural physicians—R3 [AST] and practicing physicians [Enrichment]
- d. Role of the College of Physicians and Surgeons of Alberta [CPSA] in recommending privileges
- e. Influx of internationally trained physicians [e.g., physicians from South Africa]
- f. Changes in the number of physicians in Alberta
- g. Other Factors—e.g., positions of national organizations:
 - College of Family Physicians of Canada
 - Royal College of Physicians and Surgeons of Canada and Specialty Societies
 - Society of Rural Physicians of Canada

2.1.2 FINDINGS: ENVIRONMENTAL FACTORS RESPECTING THE ADDITIONAL SKILLS TRAINING PROGRAM AND ENRICHMENT PROGRAM

Health System Restructuring

The *Regional Health Authorities Act* specifies that Regional Health Authorities are to assess, on an ongoing basis, the health needs of the region. Health needs assessments also support the other legislated responsibilities stated in Section 5 of the Act. The RHAs have a legislated mandate to determine how to use the resources of the region [financial, human, and capital resources] to meet the identified health needs. This involves, in part, examining changes in the population [both increases/decreases and changes in the age structure], and determining physician resource needs. Identifying the health needs of their respective regions provides the basis on which RHAs can encourage specific physicians, who are currently practicing in rural communities, to obtain additional competencies and/or upgrade existing skills [through the Enrichment Program].

Maturing of RPAP as a Comprehensive Program With a Variety of Initiatives

The RPAP focuses its initiatives on three distinct target groups: medical students and Residents, physicians currently in rural practice, and rural RHAs and their partner communities. There are currently over one dozen initiatives, including the third year additional skills training program for Residents, and the Enrichment Program.

Between 1991 and 1995, the RPAP was administered directly by Alberta Health and Wellness. In January 1996, independent administration of the RPAP was established through the RPAP Coordinating Committee and the Registrar of the College of Physicians and Surgeons of Alberta who was appointed as the Committee's Chair. This independent administration of the RPAP continues, and as the RPAP evolves and matures, it has increased its ability to respond effectively and efficiently in developing initiatives to influence physician recruitment and retention on behalf of the people and Government of Alberta.

Role of the University of Alberta and the University of Calgary in Training Rural Physicians

Information respecting the role of the two universities in training rural physicians appeared in the independent evaluation of the Rural Physician Action Plan, released in February 1996. The evaluation report noted that although somewhat different in administrative structure and approach to implementing the student/medical school objectives of the Rural Physician Action Plan, the faculty and administration of both the University of Alberta and the University of Calgary strongly support the principles of the RPAP.

The programming designed to enhance the attractiveness of rural practice at the University of Alberta and to enhance the medical skills and exposure of medical students and residents to rural practice is similar to that provided through the University of Calgary. However, there are some differences, which are related primarily to the history and orientation of the medical schools at the two universities. For example, the University of Alberta medical school is the oldest in the province and is known for its research focus and specialty training—and not necessarily, in the past, for its orientation towards family medicine. Moreover, the Faculty of Medicine at the University of Calgary was established because of a recognized need to increase the supply of family physicians in Canada. Stakeholders indicated that the orientation of the two medical schools and dynamic factors within each Faculty of Medicine, influences their willingness/ability to provide training in additional competencies for practicing rural general practitioners. However, it is important to acknowledge there may be a lack of congruence between the perception of practicing rural physicians and the two universities.

Role of the College of Physicians and Surgeons of Alberta

One of the many roles of the College of Physicians and Surgeons involves recommending privileges to physicians who obtain additional training in order to acquire new skills or upgrade skills that have been unused for some time. The CPSA applies specific criteria when determining whether to grant privileges, including:

- the stature/quality of the preceptor in the physician community;
- a description of the training objectives and the existing skill set of the physician in the area in which training was requested;
- the nature of the training—i.e., the educational components and procedural components of the training, including the volume of patient material; and
- a specific indication by the preceptor that all the objectives were met.

These criteria provide a context for the training experience for practicing rural physicians. Accordingly, it is critical that the training experience provides the best possible opportunity for the physician to meet these criteria were training is being arranged in response to an application to the Enrichment Program.

Influx of Internationally Trained Physicians

In the last three years there has been an influx of internationally trained physicians to Alberta from countries such as South Africa. While this has helped to alleviate some of the critical shortages of physicians in rural communities, it has also generated a significant demand for assessment of skills and additional training.

Changes in the Number of Physicians in Alberta

The Physician Resource Planning Committee (PRPC), established under the Alberta Health and Wellness/Alberta Medical Association Agreement, reported that during the next five years there is a total service need for an additional 1,329 physician FTEs (610 general practice and 719 specialist FTEs). The PRPC report indicates that the current *annual* rate of general practitioner/family physicians 'retiring plus deaths' is 43 physicians/year. This is a significant incentive for RPAP to find ways of attracting third-year residents into the Additional Skills Training Program, and to accommodate the training requirements of practicing rural physicians who were interested in upgrading existing skills or acquiring new skill sets.

Positions of National Organizations

The positions of national organizations (College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada and the Specialty Societies, Society of Rural Physicians of Canada) create a context for the development of RPAP initiatives aimed specifically at physician recruitment and retention. For example, in its report of 28 September 1999, the RPAP Coordinating Committee Working Group on Additional Skills Training stated, "The RPAP CC acknowledges that the two Faculties of Medicine at the Universities of Alberta and Calgary have, through the RPAP, accomplished a great deal regarding rural initiatives. However, the national recommendations from the family medicine accreditation body, the CFPC, provide an opportunity to strengthen rural medical education and practice in Alberta."

In addition, a consensus paper on additional skills, produced by the Society of Rural Physicians of Canada (SRPC) states:

“Concern has been expressed about providing short training programs involving surgical and technical skills. This position has been taken by some because they believe these technical and surgical procedures can only be performed safely by those with a broader base of training achieved in an extended residency training program i.e. the specialty training program is indivisible.”

“The evolution of the delivery of medical care in rural settings would refute this concern. Rural doctors give anaesthetics, manage trauma, give thrombolytics for myocardial infarction, treat pneumonia, and perform caesarean sections. It is recognized that in those clinical situations requiring technical/surgical skills in the rural setting a number of cases are transferred out for specialist consultation or management but many, if not most, are handled locally. Available data are limited but they do show that these cases can be handled appropriately in rural settings.”

These positions help to frame the debate about the legitimacy of providing training to practicing rural physicians, the role of the universities and the specialist societies in delivering the training, and in forging strategic alliances among the various stakeholders to actively addressing the recruitment and retention of rural physicians.

2.1.3 CONCLUSIONS: ENVIRONMENTAL FACTORS RESPECTING THE ADDITIONAL SKILLS TRAINING PROGRAM AND ENRICHMENT PROGRAM

There is a dynamic interplay of the environmental factors discussed in this section of the report which work together to influence the demand for additional skills training from Residents and physicians currently practicing in rural communities, as well as the responsiveness of RPAP and the Faculties of Medicine at U of C and U of A to meet these demands. This helps to frame the evaluation of both the Enrichment Program and the Additional Skills Training Program.

2.2.1 INTRODUCTION: ENRICHMENT PROGRAM

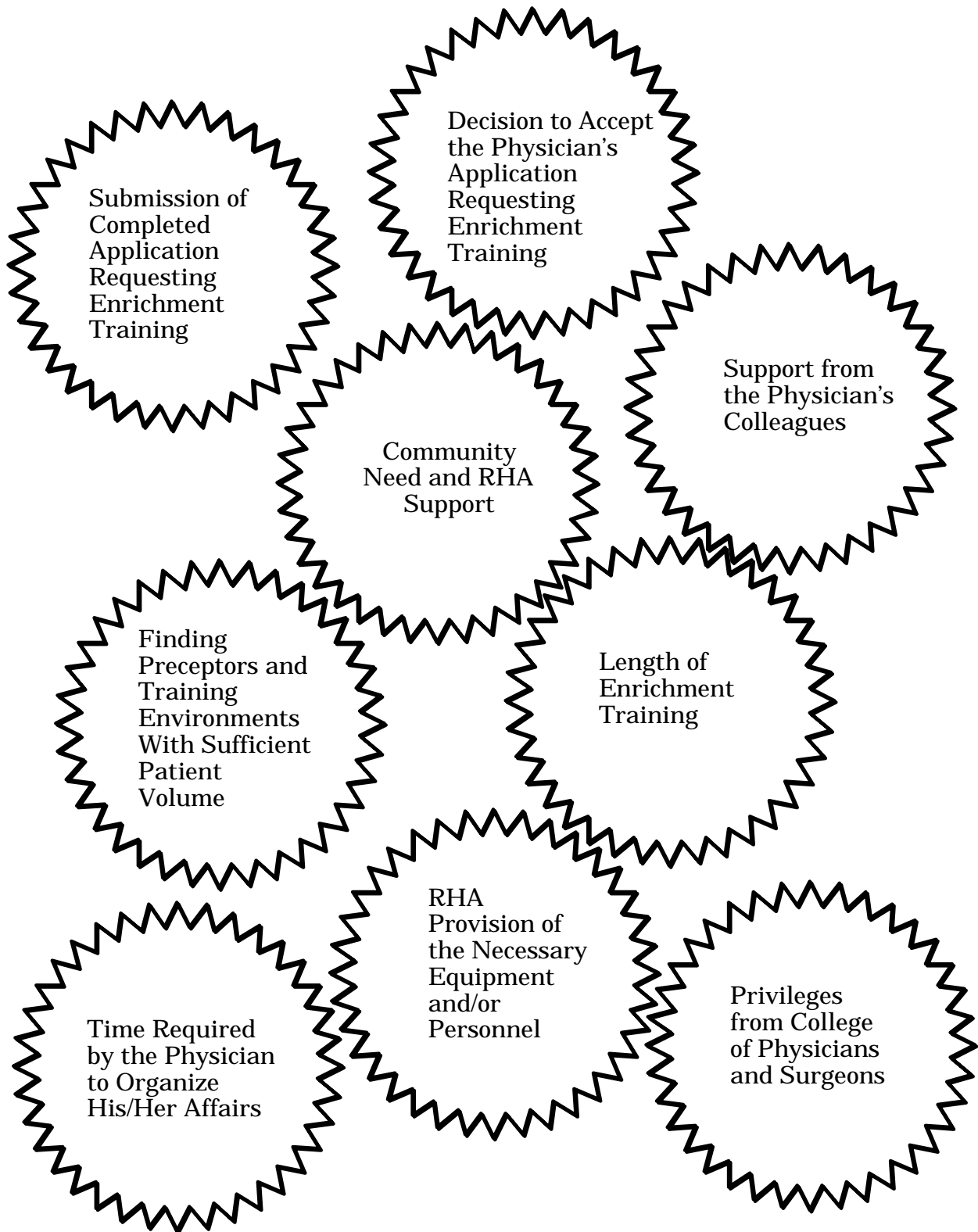
This section of the report presents our findings and conclusions respecting the Enrichment Program. The Enrichment Program provides assistance to practicing rural physicians wishing to upgrade existing skills or learn new ones. These skills must be necessary to improve the level of health services in the community or region, or to replace existing skills that will be lost due to retirement or other reasons.

2.2.2 FINDINGS: ENRICHMENT PROGRAM

Exhibit 1 indicates there are several factors, which interact with one another, like a well-oiled machine, to drive the Enrichment Program. Accordingly, it is not possible to identify only one or two factors, which either facilitate or hinder the effectiveness of achieving the objectives of the Enrichment Program. Two examples illustrate this point. First, if a practicing physician receives training through the Enrichment Program but the College of Physicians and Surgeons of Alberta deems that the physician completed an *insufficient* number of procedures and, therefore, does not recommend privileging, then the physician will not be able to use the additional skills/competencies. Second, if appropriate preceptors are located with sufficient patient volume, but the rural physician cannot leave his/her practice for the required length of time, then the applicant will not proceed with the training and no additional skills will be acquired.

EXHIBIT 1

FACTORS THAT DRIVE THE ENRICHMENT PROGRAM



During our stakeholder interviews we obtained information about each of the factors illustrated in Exhibit 1 as well as data to address each of the evaluation objectives specified in the Terms of Reference. We present our findings in the next several paragraphs.

A. Awareness of the Enrichment Program and Motivation to Apply

There are numerous ways in which physicians have become aware of the Enrichment Program. During the evaluation we interviewed 18 of 68 physicians who have received funding through the Enrichment Program since the inception of the program in 1991. Exhibit 2 indicates that RPAP and AMA publications are the most frequently cited ways physicians have become aware of the Enrichment Program. Moreover, ‘word of mouth’ from colleagues and during residency are other ways in which physicians have learned about the Enrichment Program.

EXHIBIT 2

MOST FREQUENT WAYS PHYSICIANS LEARNED ABOUT THE ENRICHMENT PROGRAM

Method of Awareness of the Enrichment Program	Number of Responses	Percent
RPAP Publications	5	25%
AMA Publications	5	25%
Colleague	4	20%
Other [RHA, Residency]	4	20%
CPSA	2	10%
Total	20	100%

NOTE: Some respondents selected more than one of the options.

Physicians applied to the Enrichment Program for funding for one of two reasons: (1) to increase their skill level and confidence in order to meet the needs of rural communities; or (2) to change the area of their practice. For example, some of the physicians we interviewed stated:

- “the community needed a physician with additional skills so I upgraded my skills in the areas of anaesthesia and epidurals”;
- “I wanted to learn how to perform caesarian sections because the physician who had been doing these procedures decided to leave the community and there was no one else to perform caesarian sections”;
- “I switched my practice from GP medicine to palliative care and I needed to upgrade my skills”; and
- “I wanted to increase my scope of practice so I took a 12-month training program in GP anaesthesia”.

B. Support of the Regional Health Authorities in the Enrichment Program Application Process

According to RPAP published information respecting the Enrichment Program, the Regional Health Authority has a responsibility to provide support for a physician’s request and to identify the need for the new skill within the region. Moreover, the RHA is suppose to demonstrate an understanding of the potential ramifications of the training in relation to utilization of RHA resources—such as nursing and/or equipment support.

We asked the 18 physicians who have received funding for training through the Enrichment Program, if they had discussed their plans with the Regional Health Authority. Most of the physicians noted they had discussed their plans with the RHA [15 of 18—83%]. In most cases, the discussions focused on the community need in relation to the training, and obtaining a letter of support from the Regional Health Authority (see Exhibit 3). However, most physicians noted that no supplementary resources (nursing or equipment) were required to support the use of their additional skills/competencies.

Only a small number of physicians [5 of 18] spoke to the RHA about the need for nursing and/or equipment required to support the additional skills/competencies. In two cases, for example, the physicians had applied for funding through the Enrichment Program for training in epidurals and discussed with their respective RHAs the need for ‘epidural kits’ and access to nurses with the appropriate training. Another physician noted he discussed the need for the RHA to develop a multidisciplinary team of ‘nursing consultants’ to support a palliative care program.

Most of the physicians [14 of 18—78%] were satisfied with the support provided by the RHA [10—‘very satisfied’, 4 ‘somewhat satisfied’]. Only one physician indicated he was ‘dissatisfied’ with the support from the RHA, while one individual was neutral about the support, and 3 other physicians stated they took their training through the Enrichment Program prior to regionalization.

EXHIBIT 3

ISSUES DISCUSSED BY PHYSICIANS AND REGIONAL HEALTH AUTHORITIES WHEN PHYSICIANS APPLY FOR FUNDING THROUGH THE ENRICHMENT PROGRAM

Discussed The Following Issues With the RHA	Number of Physicians	Percent
The Community Demand/Need in Relation to the Training You Wanted	15 of 18	83%
Obtaining a Letter of Support from the RHA	12 of 18	66%
The Types of Nursing and/or Equipment Support You Would Require After Your Training	5 of 18	28%

C. Support from the Physicians' Colleagues

Most of the physicians we interviewed practice with other physicians [14 of 18] and all of these physicians indicated they discussed their plans with their colleagues about obtaining training through the Enrichment Program. All of these physicians indicated they were 'very satisfied' with the support received from the other physicians in his/her clinic practice. Moreover, in each case, the physician's colleagues thought it was a "good idea" for the physician to pursue the acquisition of additional competencies through the Enrichment Program.

On average, the length of training was four (4) months. However, in some cases the training was in small blocks spread over two or three years [1 month/year for a period of 3 years], while in other cases the physician received training for a period of 12 consecutive months. Since most physicians spent only a small amount of time away from their practice, there was little impact on their colleagues, who had to increase their rate of on-call coverage during the time the physician was away.

D. Application Process for Funding for Training Through the Enrichment Program

Information published by RPAP outlines the current application process for the Enrichment Program. The information identifies the responsibilities of different stakeholders in the application process. Specifically:

Rural Physician

1. Provides a written rationale for learning the new skills or upgrading existing skills.
2. Provides a written commitment to return to rural practice after the training is completed.

Regional Health Authority

1. Provides support for the physician's request and identifies the need for the new skill(s) within the region.
2. Demonstrates an understanding of the potential ramifications of the training in relation to utilization of RHA resources.
3. The RHA's health facility must have the ability/approval to purchase and maintain equipment, as needed, as a result of the physician gaining the new skill.

College of Physicians and Surgeons of Alberta (CPSA)

1. Ensures, in cooperation with the Faculty of Medicine, that the applying physician has the ability to learn new skills.
2. Ensures that once the physician has gained the new skill, he/she will have the opportunity to apply it.
3. Ensures that the RHA understands the ramifications of the new skill or procedure, in terms of equipment requirements, service increases, etc.

Faculty of Medicine

1. Works closely with the CPSA to determine the applicant's determine the applicant's ability to lean the new skills and the length of training required.
2. Ensures that a qualified preceptor is available and willing to provide the necessary training.
3. Establishes learning objectives for the physician.
4. Establishes an attachment with the appropriate department within the faculty.
5. Ensures evaluation of the trainee at the end of training.
6. Provides notification to RPAP when a physician is accepted into the Enrichment Program for training.

Appointed Teaching Facility

1. Confirms the arrangements made by the other participants in the Enrichment Program.
2. The appointed teaching facility may be a hospital in an urban or regional centre.

Alberta Health and Wellness

1. Provides a letter of understanding between Alberta Health and Wellness and the physician.
2. Provides an honorarium to the physician through the Enrichment Program.

Many of the steps in the application process are invisible to the applicant. Fifteen of the 18 physicians we interviewed indicated they were 'satisfied' with the application process [11 of 18 'very satisfied', 4 'somewhat satisfied'], while one individual stated he was 'very dissatisfied' with the application process, and two other physicians indicated it was 'not applicable'.

The individual who indicated he was 'very dissatisfied' with the application process stated that "the University of Calgary stonewalled the process in arranging for a preceptor because there was resistance about teaching a general practitioner how to perform caesarian sections." Even those physicians who stated they were 'satisfied' with the application process noted it was "unclear who should be contacted" and the "communication during the application process was almost non-existent."

The RPAP Coordinating Committee (RPAP CC) established an Additional Skills Training Working Group to make recommendations and develop a plan for implementing the recommendations respecting additional skills training for Residents and practicing physicians. One of the implementation strategies accepted by the RPAP CC is the creation of an RPAP-funded "Skills Broker" position to work with the Regional Health Authorities, the College of Physicians and Surgeons of Alberta, contact individual(s) designated by each Faculty and physicians applying under the Enrichment Program for additional/advanced skills training. This position has just been recruited to. In addition, responsibility for providing the honoraria was very recently transferred to the RPAP from Alberta Health and Wellness.

The Skills Broker would:

- a. validate with the RHA and CPSA that the applicant will have the opportunity to apply the skills [it is acknowledged that the CPSA sets the standards of what will be acceptable training and evaluation];
- b. assess the applicant's ability to learn the requested skills and the length of training required;
- c. facilitate the establishment of learning objectives in conjunction with the applicant and the training organization;
- d. broker the requested training with either Faculty or other organizations; and
- e. ensure that proper evaluation occurs at the end of the training.

We believe that the Skills Broker position is a critical innovation to the Enrichment Program and will alleviate several problems we uncovered in discussion with various stakeholders. For example, in the past the University of Alberta and the University of Calgary have made judgments about: the sincerity of the applying physician with respect to continuing to practice in a rural community, the physician resource needs of the RHA, and the legitimacy of the need for training. The RPAP Skills Broker, acting as a single entry point for rural physicians into the Enrichment Program, can perform this validating role currently performed by the Faculties of Medicine.

Moreover, the University of Alberta, and the University of Calgary have not always been successful in finding preceptors with sufficient volume of suitable patient material to provide training to practicing rural physicians. Providing remuneration to preceptors will also be a benefit. In addition, some of the specialties (notably general surgery) have been resistant in training practicing rural physicians because they do not agree, in principle, with training general practitioners to perform certain procedures.

Various stakeholders noted that physicians applying to the Enrichment Program do not provide explicit training objectives. Moreover, most applicants do not provide an explicit description of the level of knowledge they have currently mastered in the skill area in which they are seeking training [e.g., the physician had received training in anaesthesia, but needs to upgrade skills in performing epidurals]. Applicants who are seeking funding through the Enrichment Program do not provide a description of the patient-environment in which the new or upgraded skill(s) will be used.

The Skills Broker can broker the requested training to ensure there is a good match between what the practicing physician wants to learn versus what the preceptor believes the physician needs to know in order to perform the procedure safely for both routine and complex cases, and what the CPSA and the RHA are prepared to support.

During our interviews with the 18 physicians we asked about the elapsed time between submitting an application for training through the Enrichment Program and receiving approval. Although the data indicate that the average elapsed time was 3 months, one physician waited 8 months to receive approval of his training request, while another waited 5 months. Notwithstanding that the physicians are waiting a lengthy period of time before their application for training through the Enrichment Program is approved, 15 of 18 physicians [83%] indicated this length of time 'was about right'.

On average, the elapsed time between receiving approval and commencing the training was 3 months—although one physician waited 7 months and another waited 6 months before commencing training. Most of the 18 physicians [15 of 18—83%] stated the length of time between approval for training and commencing the training was ‘about right’—primarily because it takes the physicians time to organize his/her personal affairs. It is expected that, in the future, the Skills Broker will be able to reduce this waiting time—particularly with respect to making arrangement with specific preceptors to provide the training.

E. Training Received Through the Enrichment Program

The average length of time of the training program for the 18 physicians we interviewed was 3 months. In some cases, the training was delivered in one block of time, such as 1 training block lasting a duration of 4 weeks, while in other cases physicians received training in a number of separate one-month blocks within the same year. However, one physician received training over a three-year period—4 weeks each year.

The training received by the 18 physicians occurred 5 days/week or 7 days/week and often included on-call responsibilities. Moreover, the training was delivered at hospitals in either Calgary or Edmonton, and most of the physicians [14 of 18—78%] had to live away from home during the training period.

Almost all of the physicians we interviewed indicated they were ‘satisfied’ with the quality of the instruction from the preceptor(s) [16 of 18—89%], primarily because the preceptor(s) was willing to teach, and inclined to let the physician do a lot of the work. Specifically, the physicians we interviewed stated:

- “I worked with a variety of preceptors so I was exposed to various ideas”;
- “preceptors understood my learning needs and the preceptor was quite available”;
- “I worked with 5 to 6 different preceptors, all of whom had good insights, and I learned six different ways of doing things”; and
- “I worked with an internationally renowned preceptor who had a succinct way of providing insights about the principles of care, the right amount of teaching, and the right amount of autonomy”.

F. Financial Compensation Received Through the Enrichment Program

Physicians accepted in the Enrichment Program receive an honorarium of \$76,000 per year, prorated for the length of training. Sixteen of the 18 physicians we interviewed received an honorarium through the Enrichment Program. On average, the physicians received the honorarium 6 weeks after commencing the training. Most of the physicians indicated this was ‘about right’ [10 of 16—63%], while 6 of the 18 physicians noted it “took too long to receive the honorarium”.

Only 1 of the 16 physicians we interviewed indicated that the honorarium received through the Enrichment Program covered **both** expenses and lost income. In all cases, the physician’s lost income was **not** covered by the honorarium received through the Enrichment Program, and in two cases the honorarium did not cover the physicians’ expenses. On average, physicians lost \$30,000 in income during the time they were receiving training through the Enrichment Program [Note: The amount of lost income ranged from \$6,000 to \$80,000, which depended on the length of the training].

G. Obtaining Privileges Upon Completion of Training Through the Enrichment Program

The College of Physicians and Surgeons of Alberta (CPSA) is responsible for licensure and for recommending privileges to physicians to practice specific skills. The CPSA believes that physicians who apply for training through the Enrichment Program should have a letter of support from the College. This process is currently not formalized, and the CPSA representative we interviewed noted that some physicians will write to the College requesting a letter of support, while others call.

The initial contact with the College of Physicians and Surgeons of Alberta is important because it provides an opportunity for the physician to discuss his/her plans with the 'privileging body'. During these discussions, the CPSA can help the physician in articulating the training objectives as they relate to the needs of the community and the background of the physician.

Although the Advisory Committee on Privileges of the CPSA meets quarterly, the Assistant Registrar has the authority to recommend privileges on an 'interim' basis. On average, the 18 physicians we interviewed waited 4 weeks to receive privileges from the CPSA to practice their new skills [Note: This ranged from 1 week to 12 weeks].

H. Using the Skills Acquired Through the Enrichment Program

Upon receiving privileges from the CPSA, most of the 18 physicians [13 of 18—72%] 'immediately' started using the skills acquired through the Enrichment Program. However, four of the 18 physicians noted it took several months before they could begin using the new skills because of severe nursing shortages and/or lack of equipment [lack of a MRI machine in one case]. Moreover, one individual stated he has 'never' used his new 'surgical obstetrical' skills because there was no anaesthetist in his community when he completed his training.

Half of the 18 physicians indicated they required specific equipment and/or the support of specific allied health professionals to use the skills acquired through the Enrichment Program. Some physicians noted they required epidural kits, supplementary drugs, and medication pumps. Physicians also indicated they required the assistance of specific allied health professionals such as pharmacists, physiotherapists, social workers, nurses [RNs], respiratory therapists, and pastoral care. In all cases, the physicians expected the Regional Health Authorities to supply the necessary equipment and/or personnel.

More than half of the 18 physicians [11 of 18—61%] are referring fewer patients to physicians located in other communities since obtaining additional competencies or upgrading existing skills through the Enrichment Program. Specifically, these physicians stated:

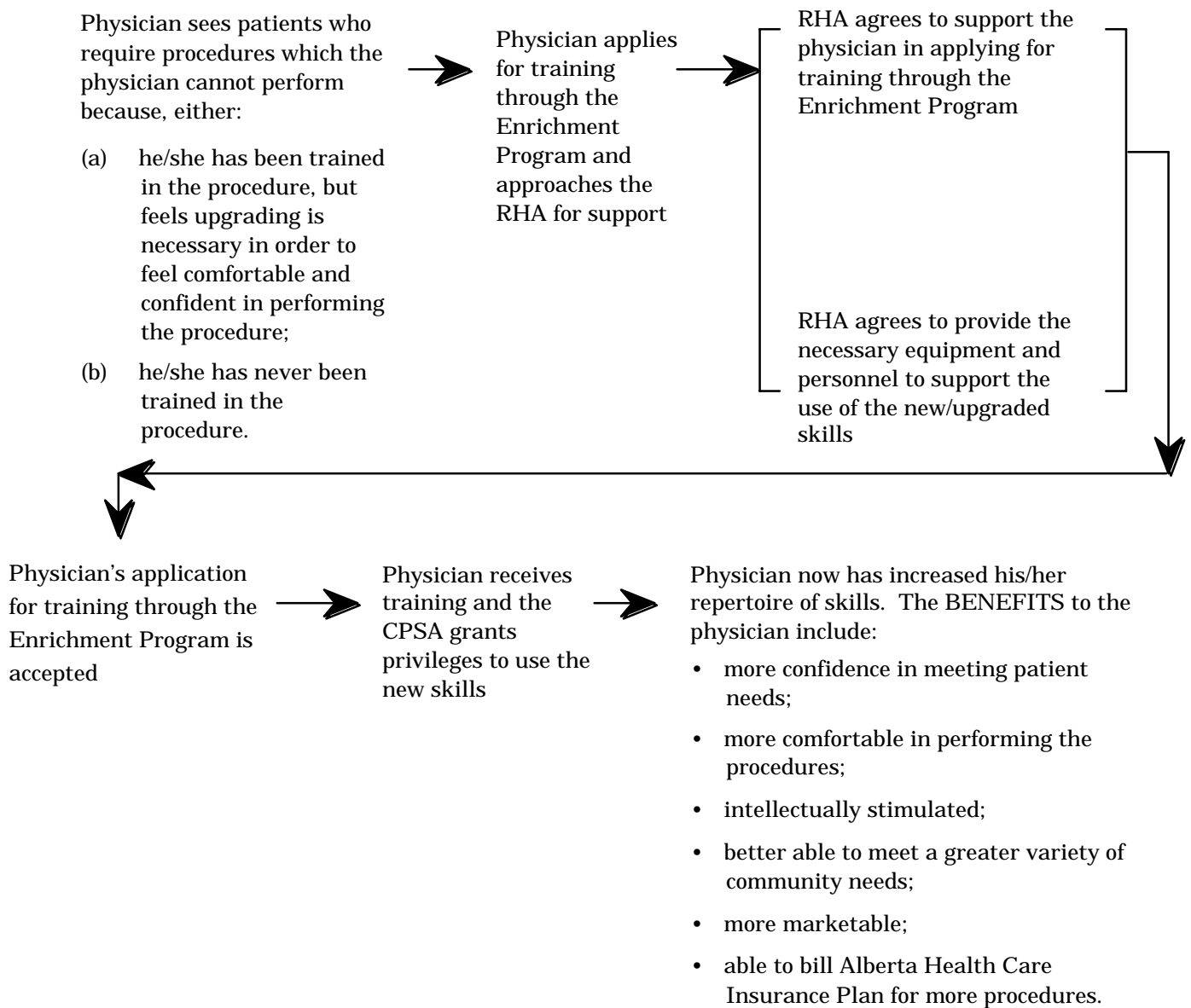
- "I can now do epidurals, so I hope to maintain more obstetrical patients within our community";
- "in the past I had to refer my palliative care patients to Calgary, but now I have the skills";
- "referrals of pain management patients to Fort McLeod and Lethbridge, and obstetrical patients to Pincer Creek have been reduced significantly"; and
- "I am referring fewer patients to Hinton".

I. Effect of the Enrichment Program on Physician Retention and Recruitment

All but one of the 18 physicians we interviewed stated that the Enrichment Program does help to retain rural physicians. However, these physicians were evenly split regarding whether the Enrichment Program helps to recruit rural physicians. As illustrated in Exhibit 4, the Enrichment Program facilitates the acquisition of additional competencies and upgrading existing skills, which helps a physician feel more confident and comfortable in performing specific procedures. Moreover, 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.

EXHIBIT 4

CURRENT ROLE OF THE ENRICHMENT PROGRAM IN RETAINING RURAL PHYSICIANS



The 18 physicians indicated they approached the Regional Health Authority for a letter of support respecting the application for funding through the Enrichment Program. While the Regional Health Authorities are willing to support practicing rural physicians in their endeavour to acquire new skills or upgrade existing skills, they have not embraced the Enrichment Program as a strategy to meet community needs. That is, few RHAs are engaging physicians in specific communities to obtain training in relation to an identified need for a specific procedure. Rather, it is often individual physicians who approach the Regional Health Authority with a request to obtain training through the Enrichment Program. The lack of promotion of the Enrichment Program by the Regional Health Authorities hinders the potential of this RPAP initiative on retaining a significant proportion of rural physicians.

2.2.3 CONCLUSIONS: ENRICHMENT PROGRAM

Physicians who participated in the evaluation indicated they have obtained several benefits from the training they received through the RPAP Enrichment Program, which help to retain them in their communities. They also specified that if the Enrichment Program is to maximize its intended objective of retaining rural physicians, then the Regional Health Authorities need to further embrace this RPAP initiative and begin promoting the Enrichment Program and engaging physicians in specific communities to obtain training in relation to an identified need for a specific procedure.

It is not possible to identify only one or two factors, which either facilitate or hinder the effectiveness of achieving the objectives of the RPAP Enrichment Program. In fact it is critical to view the Enrichment Program as composed of several factors, which interact with one another like a well-oiled machine. If any one of these factors ceases to function smoothly, it will slow down the entire process of providing training to practicing rural physicians. The Skills Broker will likely help to facilitate improving the alignment of many of the factors—including reducing the time between receipt of an application from a practicing physicians and provision of the requested training.

The current honorarium for the Enrichment Program is sufficient to meet the expenses incurred by physicians during their training. The current honorarium does **not** cover the lost income incurred by physicians who receive training through the Enrichment Program. However, there is no compelling reason for changing the amount of the honorarium.

The University of Alberta and the University of Calgary play a fundamental role in medical education. Accordingly, the Faculty of Medicine at both universities have an important role to play in the effective implementation of the Enrichment Program—that is, providing the education/training requested by practicing rural physicians and approved by the College of Physicians and Surgeons of Alberta. The Dean of Medicine at both universities should endorse this principle and communicate to the various departments within the Faculties of Medicine that this principle is to guide their interaction with the RPAP Skills Broker in arranging for training for practicing rural physicians through the RPAP Enrichment Program.

It is difficult to find preceptors who have the time and interest in: (1) preparing appropriate educational materials to meet the specified training objectives; and (2) teaching, observing, and evaluating the physicians receiving training through the Enrichment Program. Currently there is no remuneration provided to preceptors who deliver training to practicing rural physicians. Providing an honorarium as approved by the RPAP Coordinating Committee may be the incentive required to enlist the assistance of additional preceptors in the future.

2.3.1 INTRODUCTION: ADDITIONAL SKILLS TRAINING PROGRAM

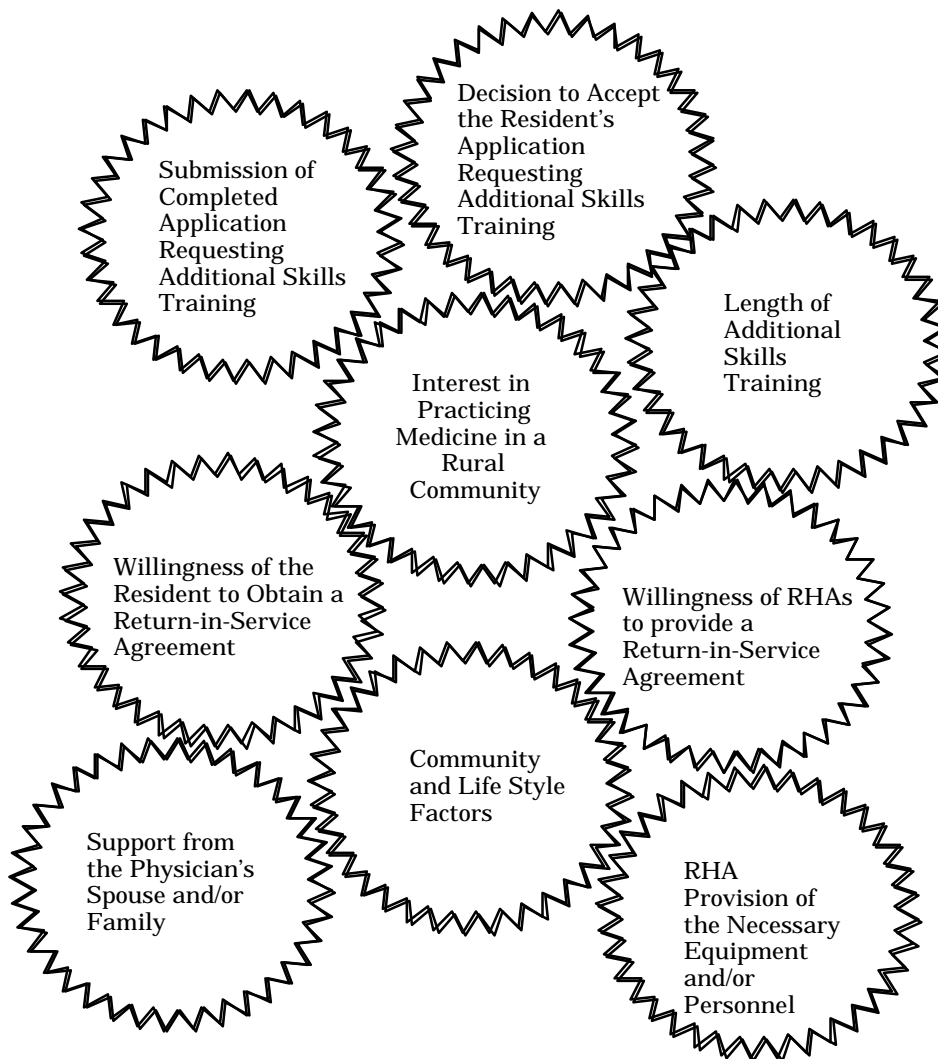
This section of the report presents our findings and conclusions respecting the Additional Skills Training Program. The objective of the AST Program is to give the trainees additional skills needed in a rural practice setting (e.g. anaesthesia, general surgery, obstetrics, emergency medicine, care of the elderly) and which are beyond the skills which the average rural physician equipped with a two year residency could reasonably be expected to have acquired.

2.3.2 FINDINGS: ADDITIONAL SKILLS TRAINING PROGRAM

Exhibit 5 indicates there are several factors, which interact with one another, like a well-oiled machine, to drive the Additional Skills Training Program. Accordingly, it is not possible to identify only one or two factors, which either facilitate or hinder the effectiveness of achieving the objectives of the AST Program. During our stakeholder interviews we obtained information about each of the factors illustrated in Exhibit 5.

EXHIBIT 5

FACTORS THAT DRIVE THE ADDITIONAL SKILLS TRAINING PROGRAM



A. Awareness of the Additional Skills Training Program and Motivation to Apply

During the evaluation we interviewed 13 of the 78 Additional Skills Training graduates. More than two-thirds of these graduates indicated they became aware of the AST Program through the Department of Family Medicine [9 of 13—69%], while another 4 individuals heard about the Additional Skills Training Program from colleagues.

The 13 AST graduates applied to the program in order to increase their skill level and confidence to meet the needs of rural communities. The following are reasons provided by some of the 13 respondents for applying to the Additional Skills Training Program:

- “I had provided locums for rural physicians for two years and I saw there was need for general practitioners who had skills in performing caesarian sections”;
- “I was completing a full month block in the Peace Region and I realized I need some additional training in anaesthesia and in dealing with trauma”;
- “I wanted to focus on surgery in a rural setting”; and
- “I knew which rural community I wanted to practice in, so I asked the community medical staff what was needed—answer was anaesthesia”.

B. Application Process for the Additional Skills Training Program

All of the Additional Skills Training graduates we interviewed were satisfied with the application process [12 of 13 were ‘very satisfied’, and 1 individual was ‘somewhat satisfied’]. Although the individuals indicated the application was straightforward, it took an average of 3 months between submission of the application and receiving approval. Most of the 13 AST graduates noted the elapsed time was ‘about right’, while 2 stated it was ‘too long’. The AST graduates did suggest, however, that the waiting time should be reduced to facilitate Residents making plans.

C. Quality of Instruction from Preceptors

All but one of the 13 AST graduates stated they were ‘very satisfied’ with the quality of the instruction from the preceptors [1 individual was ‘somewhat dissatisfied’]. The following are reasons provided by some of the 12 respondents respecting their satisfaction with the quality of instruction from the preceptors:

- “lots of volume and a good variety of patients to practice on”;
- “I was trained by specialists who were willing to have a general practitioner involved in ‘hands-on’ experience in surgery”;
- “some of my preceptors were on top of the skill sets I needed, and the preceptors at the community hospital site supported a general practitioner learning anaesthesia”;
- “the preceptors let me do a lot of the actual work”.

D. Return-in-Service Agreement and Current Practice Location

Beginning in 1997/98, the RPAP Coordinating Committee required Residents enrolled in the Additional Skills Training Program to obtain a Return-in Service Agreement (RiSA). However, only 3 of the 13 AST graduates whom we interviewed had been enrolled in the Additional Skills Training Program since the RiSA became a requirement and, each of these individuals had a Return-in Service Agreement (RiSA). In one case, the individual contacted the individual responsible for staffing at the Aspen Regional Health Authority to arrange. In another case the AST graduate contacted six different regions and spoke to several individuals—including the CEO—and asked about community needs demographics, and incentives. This individual chose WestView because the RHA was very welcoming and tried to provide everything the AST graduate requested. In addition, the CEO took the time to talk about moving expenses.

Notwithstanding the fact that most of the 13 AST graduates we interviewed did not have a Return-in-Service Agreement, more than two-thirds of these individuals are currently practicing in a rural community [9 of 13—69%], while the remaining 4 individuals practice in an urban community. The individuals who are currently practicing in a rural community indicated that the smallest community in which they would feel comfortable practicing is approximately 4,000 to 5,000 people. However, they also stated the patient-base had to be large enough to support several physicians in order to minimize the on-call schedule.

One aspect of the evaluation is to assess the extent to which the Return-in-Service commitment (RiSA) facilitates or hinders the Additional Skills Training Program. There is consensus among the stakeholders we interviewed that there are several factors involved in a Resident deciding to apply to the Additional Skills Training Program—some factors are ‘hindering’, while others are ‘facilitating’ [see Exhibit 6]. These factors interact with one another, resulting in a Resident’s decision to apply to the AST Program.

EXHIBIT 6

FACTORS INVOLVED IN A RESIDENT DECIDING TO APPLY TO THE ADDITIONAL SKILLS TRAINING PROGRAM

Hindering Factors [Listed in Order of Importance]	Facilitating Factors [Listed in Order of Importance]
1. Large Debt Load—Student Loans	1. More confidence in meeting patient needs
2. Family Medicine has prepared the physician well enough to work in rural communities—therefore, R3 Year is not a necessity	2. More comfortable in performing a wider array of procedures
3. RHA recruitment practices—signing bonuses, payment of Student Loans, other financial incentives	3. Better able to meet a greater variety of community needs
4. Family factors	4. More marketable—facilitates future career options
5. Community factors	5. Able to bill Alberta Health Care Insurance Plan for more procedures—financial benefit
6. Return-in-Service Agreement	6. Other factors—CFPC—EM, other areas such as Sports Medicine and Palliative Care

Stakeholders perceive the RiSA as a factor, which can inhibit someone from applying to the Additional Skills Training Program. However, the consensus among the stakeholders is that the other factors listed in Exhibit 6 have a stronger influence on a Resident's decision to apply to the AST Program. Moreover, there is a consensus among stakeholders that the Return-in-Service Agreement does provide some indication of an individual's commitment to actually practice medicine in a rural community.

E. Impact of the AST Program in Recruiting and Retaining Rural Physicians

Most of the 13 Additional Skills Training graduates believe the AST Program does help to recruit, as well as to retain rural physicians [9 of 13—69%, and 10 of 13—77%]. The consensus among these graduates is that the AST Program equips the individual with an appropriate level of competence and skill, which makes the physician more comfortable in his/her ability to meet the needs of the community. This helps to retain the physician in the community which he/she is serving.

It is important to point out that four of the 13 AST graduates are not convinced that the AST Program helps to recruit rural physicians [Note: these individuals currently practice in urban communities]. In addition, three of these 4 graduates stated the AST Program does *not* help to retain rural physicians.

2.3.3 CONCLUSIONS: ADDITIONAL SKILLS TRAINING PROGRAM

Physicians who attended the Additional Skills Training Program have obtained additional skills needed for a rural practice setting (e.g. anaesthesia, general surgery, obstetrics) and which are beyond the skills, which the average rural physician equipped with a two year residency, could reasonably be expected to have acquired. These physicians believe that the AST Program equips the individual with an appropriate level of competence and skill, which makes the physician more comfortable in his/her ability to meet the needs of the community.

The Return-in-Service Agreement may negatively affect an individual's decision about applying to the Additional Skills Training Program. However, its influence is far less significant than such factors as the 'debt-load' of the applicant, RHA recruitment practices, and family influences.

The Additional Skills Training Program provides benefits to the Regional Health Authorities, since graduates obtain additional skills needed for a rural practice setting. Accordingly, the Regional Health Authorities should play a greater role in promoting the Additional Skills Training Program to 2nd-Year Residents.

POINTS TO PONDER

3.0 INTRODUCTION

This section of the report presents some points to ponder respecting the issues surrounding the Additional Skills Training Program and the Enrichment Program.

3.1 POINTS TO PONDER ABOUT THE ADDITIONAL SKILLS TRAINING PROGRAM AND THE ENRICHMENT PROGRAM

A. Degree of Congruence Between the Objectives of the Additional Skills Training Program and the Current Course Offerings

The Additional Skills Training Program can be viewed within the spectrum of medical education. For example, at the University of Alberta, an undergraduate rotation in family medicine became mandatory in 1997. In addition, there is a 4-week mandatory Rural Family Medicine clinical rotation, which provides exposure to the challenges and opportunities of rural family practice in Alberta. Moreover, at the University of Alberta Family Medicine Residency Program, opportunities for rural experience come in the residents' second year, where residents can do either 4, 16 or 20 weeks of family medicine in one of 10 rural residency training locations.

Residents are exposed to the challenges faced by rural physicians and the required skills to meet community needs. The Additional Skills Training Program offers further training to residents in the following areas: anaesthesia, obstetrics, surgery, sports medicine, geriatric medicine, palliative care, and emergency medicine [CFPC—EM]. Some of these programs may be offered in combination with each other—such as surgery/obstetrics, obstetrics/emergency, and care of the elderly/palliative care.

According to Exhibit 7, the majority of AST graduates completed training in emergency medicine. Moreover, Care of the Elderly/Palliative Care accounts for 21 percent of the AST graduates [16 of 78]. Since most of the AST graduates in emergency medicine, and care of the elderly/palliative care work in urban communities, there is a lack of congruence between the objectives of the Additional Skills Training Program and some of the course offerings. This issue needs to be examined by the RPAP Coordinating Committee. In addition, the RPAP Coordinating Committee should identify the relationship between the Additional Skills Training Program and the new core postgraduate curriculum for rural family practice and the rural family medicine stream—the Alberta Rural Family Medicine Network.

EXHIBIT 7

NUMBER OF GRADUATES FROM THE AST PROGRAM AT THE UNIVERSITY OF ALBERTA BY DISCIPLINE BETWEEN 1992 AND 1999

Discipline	Number of Graduates Between 1992 and 1999	Percent
CFPC—EM	32	41%
Anaesthesia	13	17%
Surgery/Obstetrics	12	16%
Care of the Elderly	11	14%
Obstetrics/Emergency	3	4%
Care of the Elderly/Palliative Care	2	3%
Obstetrics/Paediatrics	1	1%
Palliative Care/Native Health	1	1%
Gastrointestinal Medicine	1	1%
Orthopaedics/Care of the Elderly	1	1%
Sports Medicine/Care of the Elderly	1	1%
Total	78	100%

SOURCE: Annual Report: Rural Medical Education at the University of Alberta: July 1, 1998 to June 30, 1999, March 1, 2000.

B. Determining Standards for Training

The RPAP Coordinating Committee should take a leadership role of involving stakeholders—including the CPSA, through a transparent process, to develop standards for training. Developing these standards should lead to a consistency of training for rural general practitioners, in order that they can attain additional competencies.

C. Increasing the Role of the Regional Health Authorities in Promoting the Additional Skills Training Program and the Enrichment Program

Regional Health Authorities are responsible for developing physician manpower objectives and ensuring there are the right physician resources in the right locations to meet community needs. Both the Additional Skills Training Program and the Enrichment Program can assist the RHAs in meeting these responsibilities. Accordingly, the RPAP Coordinating Committee should work with each of the rural Regional Health Authorities to ensure they are promoting both the AST and Enrichment Programs within the context of their physician resource needs.

D. Providing Training Through the Enrichment Program in Small Time Blocks

Providing training to practicing physicians in short time blocks acknowledges the difficulties they and their colleagues face when the individual is away from the community for an extended period of time. Some stakeholders made a compelling argument that practicing physicians are skilled practitioners with several years experience and, therefore, they do not require as much time as Residents to learn new procedures or upgrade existing skills. Others countered that learning certain procedures requires the physician to be immersed in training for a long block of time. These individuals asserted that breaking a large block of time into small portions, spread over a long period, only dilutes the intensity of the training experience—thereby weakening the very skills that the physician wanted to strengthen.

The 18 physicians we interviewed had mixed views about whether training for practicing physicians should be offered in short or long time blocks. Specifically, 8 of 18 physicians [44%] indicated it is better to provide training to practicing physicians in short time blocks. The rationale for obtaining training in short time blocks is best exemplified by one physician who stated, “it is almost impossible to take a substantial amount of time away from your practice.” However, 10 of the 18 physicians we interviewed [56%] noted that the length of the training should relate to the training objectives and the procedures the physician wants to learn. Their point of view is best exemplified by one physician who stated, “to learn some types of procedures you need to be immersed in the training for a longer period of time.”

E. Locum Coverage for Practicing Physicians In Order to Obtain Training Through the Enrichment Program

Four of the 18 physicians we interviewed respecting the Enrichment Program arranged for a locum and all but one individual arranged for a ‘private’ locum, while one locum was organized through the AMA Rural Locum Program. Two of these four physicians indicated it was ‘very difficult’ to find a locum, while two noted it was ‘easy’ to arrange the locum. The other 14 physicians we interviewed stated their colleagues provided the necessary coverage while the individual received training through the Enrichment Program.

The RPAP Coordinating Committee should attempt to identify options respecting coverage to practicing physicians who want to obtain training through the Enrichment Program—particularly when the training requires the physician to be away from his/her practice of longer than 3 months. If RPAP can provide realistic options for physicians to obtain coverage while they are receiving training through the Enrichment Program, these options could be included in the promotion of the program. This could help to encourage a greater number of physicians in applying for funding through the Enrichment Program, because it removes an potential barrier to the physicians taking time from their practice to either upgrade their skills or acquire new skills.

F. Identifying Preceptors to Provide Training to Practicing Rural Physicians Through the Enrichment Program

To ensure that practicing rural physicians can access training through the Enrichment Program quickly requires the availability of preceptors who have the time and the interest in: (1) preparing appropriate educational materials to meet the specified training objectives; and (2) teaching, observing, and evaluating the physicians receiving Enrichment Training. In addition, these preceptors need to have ready access to patient material, in sufficient volume, to be able to teach the practicing physician what he/she wants to learn and what the preceptor believes the physician needs to know in order to perform the procedure safely for **both** routine and complex cases.

Stakeholders indicated that there is a shortage of physicians willing to assume the role of preceptor. They cite the following reasons for this lack of interest:

- There is a lack of physicians in some specialties and, therefore, potential preceptors for the Enrichment Program would prefer to invest their time in teaching 4th-Year Residents in their own specialty.
- Specialists are already carrying a large load—teaching and patient care responsibilities.
- There is no honorarium for the preceptors who provide Enrichment Training.

Some stakeholders believe that offering potential preceptors an honorarium would help to entice physicians to provide training to practicing rural physicians, and suggested that an honorarium of approximately \$500 per trainee would be sufficient. The RPAP Additional Skills Technical Working Group recognized this issue in its Implementation Plan of March 2000, and it recommended an honorarium of \$1,000 per trainee month.

There are several factors involved in finding appropriate preceptors to train practicing rural physicians through the Enrichment Program. Exhibits 8 through 12 provide several examples of the processes used by different departments at the University of Alberta and University of Calgary in arranging for preceptors to train practicing rural physicians in the areas of palliative care, obstetrics, anaesthesia, and surgery.

EXHIBIT 8

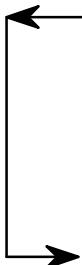
UNIVERSITY OF ALBERTA: PROCESS OF ARRANGING FOR PRECEPTORS TO TRAIN PHYSICIANS IN THE AREA OF PALLIATIVE CARE

Practicing rural physicians who are interested in obtaining training through the Enrichment Program in Palliative Care phone Dr. Sharon Watanabe



The physician writes a letter to Dr. Watanabe which includes:

- reason for the interest in learning about palliative care;
- training objectives;
- curriculum vitae;
- length of time living in the RHA;
- support from the RHA;
- length of training—e.g., 2 weeks, 4 weeks, or longer.



Dr. Watanabe brings the letter to the Postgraduate Training Committee for review. If the Committee accepts applicant, the Committee coordinates the training to ensure there is sufficient patient volume



When the training in palliative care is **less than 4 weeks**, Dr. Watanabe places the physician at the palliative care unit at the Grey Nuns Hospital

When the training in palliative care is **more than 4 weeks**, Dr. Watanabe places the physician at the palliative care unit at the Grey Nuns Hospital for the first 4 weeks, and then Dr. Watanabe places the rural physician with a “Palliative Care Physician” and two physicians travel together to various communities within the region providing palliative care services.

EXHIBIT 9

UNIVERSITY OF ALBERTA: PROCESS OF ARRANGING FOR PRECEPTORS TO TRAIN PHYSICIANS IN THE AREA OF OBSTETRICS

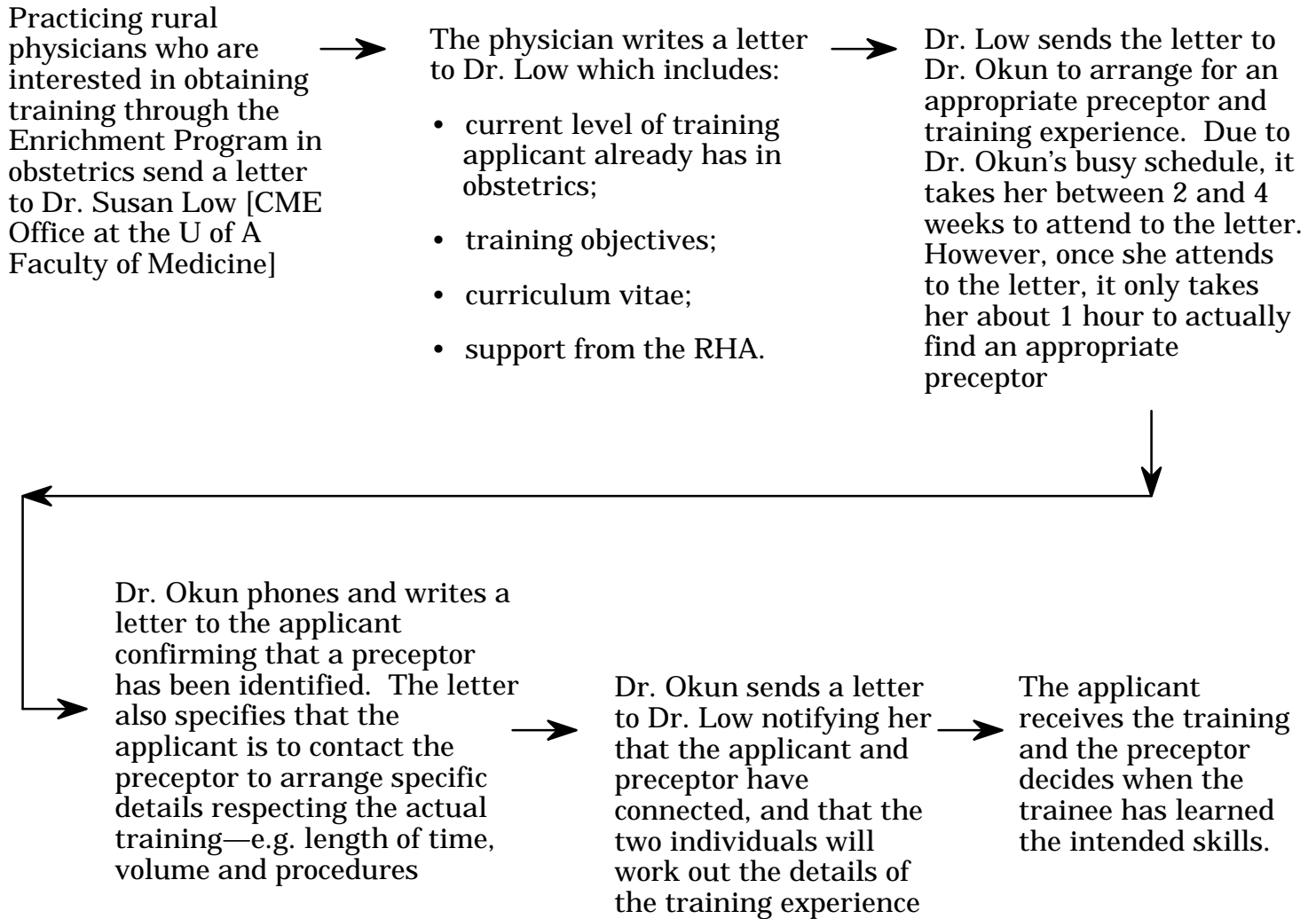


EXHIBIT 10

UNIVERSITY OF ALBERTA: PROCESS OF ARRANGING FOR PRECEPTORS TO TRAIN PHYSICIANS IN THE AREA OF ANAESTHESIA

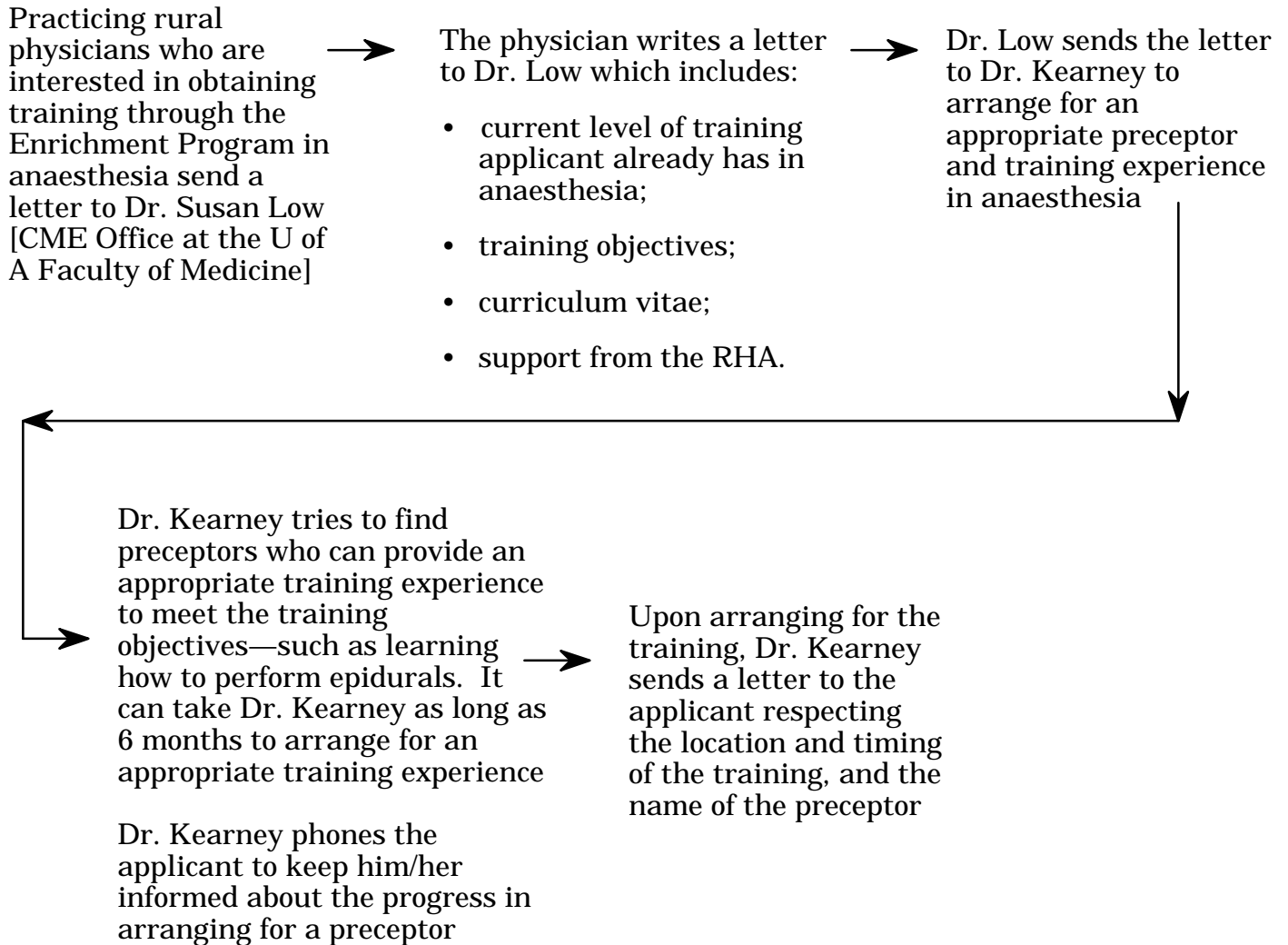


EXHIBIT 11

UNIVERSITY OF CALGARY: PROCESS OF ARRANGING FOR PRECEPTORS TO TRAIN
PHYSICIANS IN THE AREA OF ANAESTHESIA

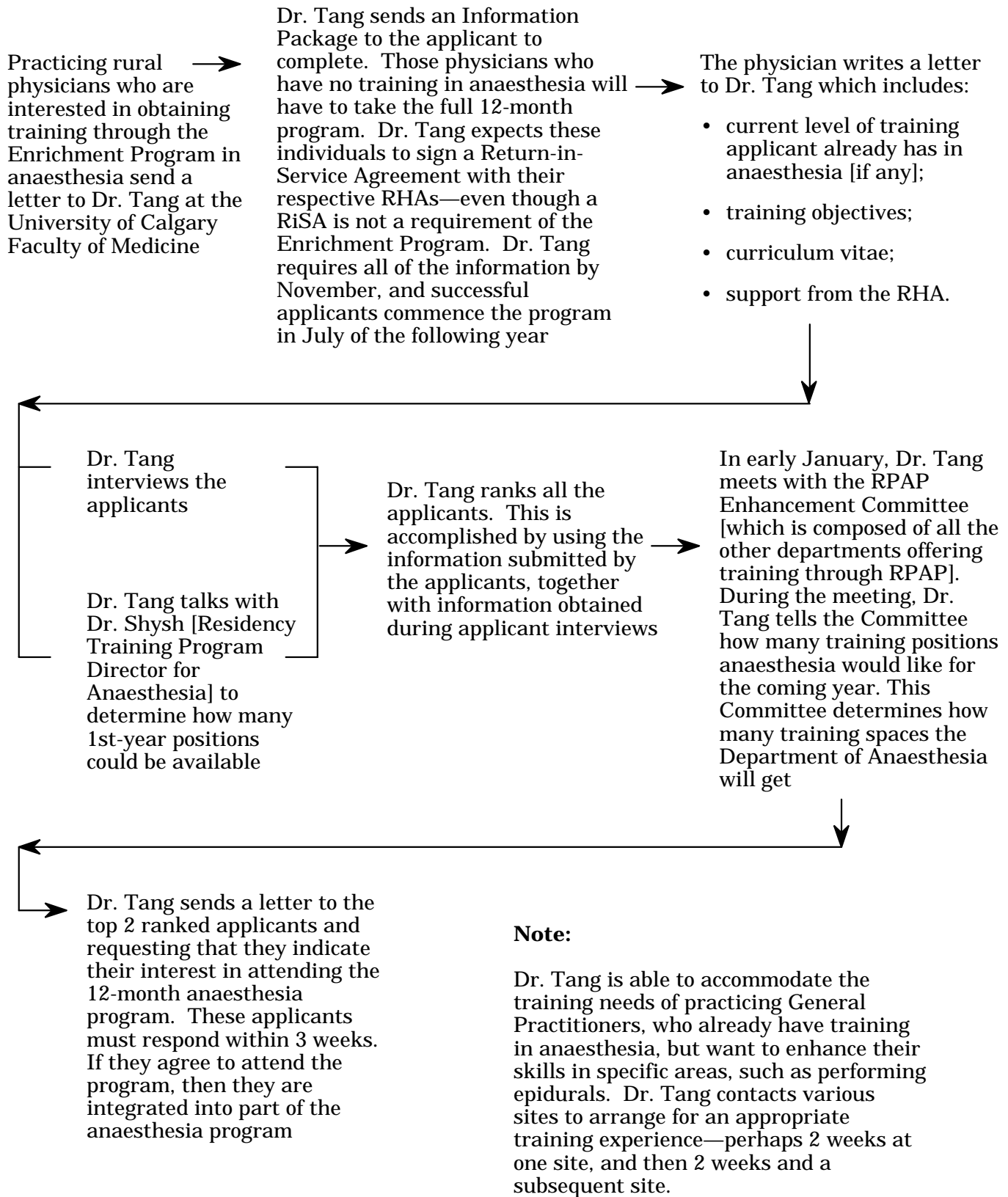


EXHIBIT 12

UNIVERSITY OF CALGARY: PROCESS OF ARRANGING FOR PRECEPTORS TO TRAIN PHYSICIANS IN THE AREA OF SURGERY

