PHYSICIAN RETENTION IN RURAL ALBERTA:
AN UPDATE OF POCKETS OF GOOD NEWS (1994)

30 March 2002

Prepared for the Rural Physician Action Plan

By

C.A. MacDonald and Associates
PHYSICIAN RETENTION IN RURAL ALBERTA:  
An Update of Pockets of Good News (1994) 

TABLE OF CONTENTS 

Table of Contents ................................................................................................................................. i 
List of Tables ........................................................................................................................................ ii 

Physician Retention in Rural Alberta: ............................................................................................... 1 

Background and Context ...................................................................................................................... 1 
  Information about the Database Used in this Report ................................................................. 1 

Profile of Rural Physicians in Alberta .............................................................................................. 2 
  Location of Rural Physicians in Alberta .................................................................................. 2 
  Physician/Population Ratios ...................................................................................................... 3 
  Year of Graduation ..................................................................................................................... 4 
  Distribution by Community Size .............................................................................................. 6 
  Place of Training ......................................................................................................................... 6 

Recruitment of Rural Physicians ..................................................................................................... 8 
  Attracting Physicians to Rural Alberta .................................................................................. 8 
  Recruitment Patterns in Rural Alberta .................................................................................. 8 
  Rural Recruitment Practices .................................................................................................. 10 
    From the Regional Medical Directors’ Perspective .......................................................... 10 
    From the Residents’ Perspective ......................................................................................... 13 
    From the Physicians’ Perspective ....................................................................................... 13 

Retention of Rural Physicians .................................................................................................... 15 
  What is “Successful Retention?” .............................................................................................. 15 
  Retention Patterns ................................................................................................................... 15 
  Physicians Leaving Rural Practice .......................................................................................... 18 
    “Uncontrollable” Reasons for Leaving .............................................................................. 18 
    “Controllable” Reasons for Leaving .................................................................................. 19 
  Retaining Physicians in Rural Alberta .................................................................................. 20 
    From the Regional Medical Directors’ Perspective .......................................................... 20 
    From the Residents’ Perspective ......................................................................................... 21 
    From the Rural Physicians’ Perspective ........................................................................... 22 
  Involving the Community ......................................................................................................... 23 
  Physician Recruitment and Retention Initiatives in Other Provinces ................................. 24 
  RPAP’s Action Plan for Retention of Rural Physicians: 2001-2002 and Beyond ............ 26 

Summary and Conclusions ........................................................................................................... 27 

Appendix 1 – Recruitment and Retention of Rural Physicians in Other Provinces .......... 30 
  British Columbia .................................................................................................................. 30 
  Manitoba ............................................................................................................................. 32 
  Ontario ............................................................................................................................... 32 
  Newfoundland ...................................................................................................................... 34 
  New Brunswick ..................................................................................................................... 35 

Appendix 2 – Some Good News Stories ....................................................................................... 36 
  Community .......................................................................................................................... 36 
  Family/Lifestyle .................................................................................................................... 38 
  Professional ............................................................................................................................ 39
LIST OF TABLES

Table 1 - Number of Rural Physicians in Alberta.................................................................2
Table 2 – Physician/Population Ratios, Selected Years..........................................................3
Table 3 – Year of Graduation – 5-year Groups by Region - 2001 ................................................5
Table 4 – Towns by Number of Doctors, Selected Years..........................................................6
Table 5 – Place of Under-Graduate Education (Excluding Regional Centres)................................7
Table 6 – Movement of Physicians in Rural Alberta, 1987 - 2001.............................................9
Table 7 – Source of New Physicians – 1996 to 2001.................................................................10
Table 8 – Retention Patterns for All Rural Physicians – 1996 - 2001.........................................15
Table 9 – Rural Retention Rates – 1996 - 2001......................................................................16
Table 10 – Years of Practice in Rural Alberta for Physicians Practising in 2001......................17
PHYSICIAN RETENTION IN RURAL ALBERTA:

An Update of Pockets of Good News (1994)

Background and Context

In 1994, a study entitled “Pockets of Good News”\(^1\) was commissioned by the Rural Physician Action Plan (RPAP) Coordinating Committee to assess what Alberta communities were doing to recruit and retain physicians. Later, in 1996, all of the programs that comprised the Rural Physician Action Plan were evaluated\(^2\), providing information regarding the impact of the Rural Physician Action Plan initiatives on physician recruitment and retention.

RPAP is implementing a new work plan, “Retention of Rural Physicians: An Action Plan for 2001-2002 and Beyond”\(^3\), which was developed through a multi-stakeholder consultation process at the direction of the RPAP Coordinating Committee. The work plan offers priorities for each of the main factors influencing physician retention — professional, family/lifestyle and community. As well, in April 2001, two Rural Physician Consultants were brought on board to work collaboratively with physicians, rural health authorities and community representatives to address rural physician recruitment, retention and training issues.

This report provides an update to Pockets of Good News and the 1996 RPAP Evaluation, with a particular focus on physician retention. The objectives of this study include:

1. To update the findings of the 1994 study relative to rural physician recruitment;
2. To identify learnings relative to rural physician retention; and
3. To recommend changes to RPAP programs.

To meet these objectives, the consultants interviewed or received input from all of the regional Medical Directors with the exception of one; 33 rural physicians; medical residents from both the University of Alberta and University of Calgary; several community-based individuals; and a number of key stakeholders with Alberta Health and Wellness, Alberta Medical Association, and the RPAP. As well, the provinces were contacted for information about their rural physician retention strategies (as part of another project undertaken by the consultants). Several provinces did provide information, included as Appendix 1, starting on page 30.

Information about the Database Used in this Report

The consultants for this report, C.A. MacDonald and Associates, maintain a database of all physicians in Alberta, based on the annual College of Physicians and Surgeons Physician Register publication. This database documents the movement of all Alberta physicians from 1986 to 2001. It is a cross-section file, identifying all physicians practising in Alberta at the

---


February cut-off date for publication as represented at that point in the College of Physicians and Surgeons main database. There are a few limitations for the data contained in this database:

- Physicians who practiced in Alberta for less than a full year (in particular, those who are not practicing specifically on the February cut-off date) are not included in the database. Thus, physicians who practice in Alberta strictly as locums may not be included in the database;

- Similarly, physicians who practiced in a rural area for less than one year prior to moving to an urban centre may not be captured as ever working in a rural area, if the rural practice period did not encompass a February practice period;

- Physicians are notoriously poor at reporting retirement to the college. For professional reasons, many physicians keep their licence active even though they have fully or partially retired. This results in the database overstating the number of physicians actually in practice in the various locations around the province; and

- The address for which a physician may be registered may be the home or billing address rather than the address of the practice. Over the years, corrections have been made to the database to try and ensure that the physician is registered to the actual practice address/region rather than the home or billing address.

However, these limitations are minor compared to the consistency and usefulness of the overall database. The database was originally designed as a rural physician database. In 1997, however, C. A. MacDonald & Associates began adding urban physicians to the database, and the full database now includes both rural and urban physicians practising in Alberta from 1996 to the present.

### Profile of Rural Physicians in Alberta

The original “Pockets of Good News” study, as well as the 1996 Evaluation of the Rural Physician Action Plan analyzed practice patterns for rural physicians up to 1996. This report brings data for practice patterns up to date to 2001.

#### Location of Rural Physicians in Alberta

Table 1 - Number of Rural Physicians in Alberta

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinook #1</td>
<td>53</td>
<td>62</td>
<td>56</td>
<td>54</td>
<td>48</td>
<td>55</td>
<td>58</td>
<td>59</td>
</tr>
<tr>
<td>Lethbridge</td>
<td>132</td>
<td>134</td>
<td>146</td>
<td>142</td>
<td>151</td>
<td>151</td>
<td>164</td>
<td>170</td>
</tr>
<tr>
<td>Total Region</td>
<td>186</td>
<td>196</td>
<td>202</td>
<td>196</td>
<td>199</td>
<td>206</td>
<td>222</td>
<td>229</td>
</tr>
<tr>
<td>Palliser #2</td>
<td>20</td>
<td>23</td>
<td>20</td>
<td>24</td>
<td>21</td>
<td>26</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>Medicine Hat</td>
<td>56</td>
<td>72</td>
<td>72</td>
<td>75</td>
<td>80</td>
<td>85</td>
<td>85</td>
<td>86</td>
</tr>
<tr>
<td>Total Region</td>
<td>76</td>
<td>85</td>
<td>92</td>
<td>99</td>
<td>101</td>
<td>111</td>
<td>110</td>
<td>112</td>
</tr>
<tr>
<td>Headwaters #3</td>
<td>57</td>
<td>68</td>
<td>88</td>
<td>85</td>
<td>90</td>
<td>94</td>
<td>103</td>
<td>105</td>
</tr>
<tr>
<td>Region #5</td>
<td>33</td>
<td>35</td>
<td>39</td>
<td>33</td>
<td>36</td>
<td>40</td>
<td>41</td>
<td>39</td>
</tr>
</tbody>
</table>
Prior to 1996, the peak number of rural physicians was reached in 1992, immediately before regionalization, with 699 rural physicians practising in Alberta. This decreased to a low of 658 in 1997. Major recruitment efforts in 1998 and 1999 have supported a steady increase in the total number of rural physicians, to 795 in 2001.

**Physician/Population Ratios**

Table 2 – Physician/Population Ratios, Selected Years
### Physician Retention in Rural Alberta

<table>
<thead>
<tr>
<th>Region</th>
<th>1995</th>
<th>1998</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lakeland #12</td>
<td>1:1,221</td>
<td>1:845</td>
<td>1:754</td>
</tr>
<tr>
<td>Mistahia #13</td>
<td>1:1,026</td>
<td>1:1,133</td>
<td>1:1,081</td>
</tr>
<tr>
<td>Peace #14</td>
<td>1:1,337</td>
<td>1:1,596</td>
<td>1:1,204</td>
</tr>
<tr>
<td>Keeweetinok Lakes #15</td>
<td>1:1,373</td>
<td>1:1,641</td>
<td>1:1,219</td>
</tr>
<tr>
<td>Northwestern #17</td>
<td>1:1,783</td>
<td>1:2,370</td>
<td>1:1,848</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1:1,021</td>
<td>1:1,049</td>
<td>1:956</td>
</tr>
</tbody>
</table>

This table includes the population and both family physicians and specialists in the regional centres. As the above table indicates, there has been a consistent downward trend in the population served by each doctor in rural Alberta. Some regions, Lakeland and Palliser in particular, have shown a significantly strong trend in reducing the physician/population ratio.

**Note:** All further tables in this report refer only to rural physicians, without including physicians in regional centres, unless specified otherwise.

### Year of Graduation

The database does not contain the age of Alberta rural physicians. Therefore, year of graduation was used as the closest available proxy. We estimated that a physician is 24 when he/she completes undergraduate training. Thus, we estimated age on the following basis. These are the key age groups for determining retirement patterns of rural physicians in the next 15 – 20 years.

Under 50 – Graduated after 1975  
50 – 55 – Graduated between 1970 and 1974  
55 – 60 – Graduated between 1965 and 1969  
60 – 65 – Graduated between 1960 and 1964  
65 – 70 – Graduated between 1955 and 1959  
70 – 75 – Graduated between 1950 and 1954  
75 and over – Graduated before 1950
## Table 3 – Year of Graduation – 5-year Groups by Region - 2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinook #1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>20</td>
<td>1.5%</td>
</tr>
<tr>
<td>Lethbridge Total</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>16</td>
<td>9</td>
<td>15</td>
<td>21</td>
<td>32</td>
<td>40</td>
<td>20</td>
<td>152</td>
<td>11.6%</td>
</tr>
<tr>
<td>Palliser #2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>23</td>
<td>1.5%</td>
</tr>
<tr>
<td>Medicine Hat</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>14</td>
<td>19</td>
<td>16</td>
<td>18</td>
<td>9</td>
<td>39</td>
<td>6.3%</td>
</tr>
<tr>
<td>Palliser Total</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>17</td>
<td>21</td>
<td>19</td>
<td>23</td>
<td>15</td>
<td>72</td>
<td>4.4%</td>
</tr>
<tr>
<td>Headwaters #3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>21</td>
<td>13</td>
<td>24</td>
<td>22</td>
<td>152</td>
<td>15.2%</td>
</tr>
<tr>
<td>Region #5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>7</td>
<td>6</td>
<td>42</td>
<td>4.4%</td>
</tr>
<tr>
<td>David Thompson #6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>14</td>
<td>18</td>
<td>20</td>
<td>21</td>
<td>24</td>
<td>12</td>
<td>1.5%</td>
</tr>
<tr>
<td>Red Deer</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>14</td>
<td>25</td>
<td>23</td>
<td>17</td>
<td>33</td>
<td>20</td>
<td>64</td>
<td>6.8%</td>
</tr>
<tr>
<td>Red Deer Total</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>13</td>
<td>18</td>
<td>39</td>
<td>41</td>
<td>37</td>
<td>54</td>
<td>44</td>
<td>152</td>
<td>11.6%</td>
</tr>
<tr>
<td>East Central #7</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>13</td>
<td>12</td>
<td>14</td>
<td>18</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Westview #8</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>16</td>
<td>14</td>
<td>15</td>
<td>14</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Crossroads #9</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Aspen #11</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>10</td>
<td>6</td>
<td>16</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Lakeland #12</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>10</td>
<td>13</td>
<td>18</td>
<td>18</td>
<td>19</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Sherwood Park</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>9</td>
<td>10</td>
<td>7</td>
<td>6</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Sherwood Park Total</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>19</td>
<td>22</td>
<td>28</td>
<td>25</td>
<td>25</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Mistahia #13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>10</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Grande Prairie</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>15</td>
<td>11</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Grande Prairie Total</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>9</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>20</td>
<td>14</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Peace #14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Keewatin Lakes #15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td>Northwestern #17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>40</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>20</td>
<td>21</td>
<td>32</td>
<td>83</td>
<td>89</td>
<td>152</td>
<td>200</td>
<td>214</td>
<td>265</td>
<td>237</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Using normal retirement ages, it can be seen from this table that approximately 5.5% or 73 rural physicians have already reached the age of 65 (graduation prior to 1960), particularly in Chinook and Palliser. These physicians could partially or completely retire at any time. Another 172 rural physicians (or 13.1%) are between 55 and 65 and could be expected to retire sometime in the next 10 years. 352 rural physicians (or 26.5%) are in the 45 to 55 year old age group, and could be expected to retire sometime in the next 10 to 20 years.

Clearly, we can expect nearly 600 physician retirements over the next 20 years (or approximately 30 retirements per year). These physicians will require replacement, without taking into account other reasons for physicians leaving rural practice, or taking into account population growth in the rural areas.

**Distribution by Community Size**

**Table 4 – Towns by Number of Doctors, Selected Years**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Physician</td>
<td>25</td>
<td>31</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>2 Physicians</td>
<td>24</td>
<td>17</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>3 Physicians</td>
<td>13</td>
<td>11</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>4 Physicians</td>
<td>14</td>
<td>14</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>5 or more Physicians</td>
<td>49</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>Total Communities</td>
<td>125</td>
<td>129</td>
<td>125</td>
<td>121</td>
</tr>
<tr>
<td>Total Physicians</td>
<td>628</td>
<td>689</td>
<td>690</td>
<td>795</td>
</tr>
<tr>
<td>Average # of Physicians per community</td>
<td>5.03</td>
<td>5.34</td>
<td>5.53</td>
<td>6.57</td>
</tr>
</tbody>
</table>

NOTE: Excludes regional centres

Between 1995 and 2001, the number of physicians working in rural communities increased by 105. In 1986 there were 168 physicians working in towns with 1-4 physicians, whereas in 2001, there were 140 physicians working in towns with 1-4 physicians. However, there was an internal shift between one-physician towns and 2 – 4 physician towns, with a drop of almost 50% in the number of towns with one physician (from 25 to 14). When one accounts for the fact the data is based on a snapshot of physicians as of February each year, the total of one-physician communities for 2001 reduces to 9, since 5 communities had recruited at least one additional physician by December 2001.

There are 150 more physicians working in rural Alberta since 1995 in towns with 5 or more physicians. This is consistent with information gathered in the physician interviews and focus groups with family medicine residents when most participants indicated that once the decision had been made to practice in a rural area the crucial factor in deciding where to establish a practice in rural Alberta was the on-call requirements. In communities with 5 or more physicians to share the on-call responsibilities, the burden on each physician is much less.

**Place of Training**

The table on the next page indicates the undergraduate training location for physicians by region. The database does not contain information about the location of post-graduate training.
Table 5 – Place of Under-Graduate Education (Excluding Regional Centres)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>U of A</td>
<td>U of C</td>
<td>Canada</td>
<td>Other</td>
</tr>
<tr>
<td>Chinook #1</td>
<td>27</td>
<td>1</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Palliser #2</td>
<td>8</td>
<td>0</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Headwaters #3</td>
<td>20</td>
<td>11</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Region #5</td>
<td>11</td>
<td>2</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>David Thompson #6</td>
<td>23</td>
<td>9</td>
<td>11</td>
<td>38</td>
</tr>
<tr>
<td>East Central #7</td>
<td>29</td>
<td>5</td>
<td>13</td>
<td>42</td>
</tr>
<tr>
<td>Westview #8</td>
<td>17</td>
<td>3</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Crossroads #9</td>
<td>9</td>
<td>0</td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>Aspen #11</td>
<td>18</td>
<td>1</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Lakeland #12</td>
<td>21</td>
<td>5</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>Mistahia #13</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Peace #14</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Keewatin Lakes #15</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Northwestern #17</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>206</td>
<td>37</td>
<td>99</td>
<td>286</td>
</tr>
<tr>
<td>Percent</td>
<td>32%</td>
<td>6%</td>
<td>16%</td>
<td>46%</td>
</tr>
</tbody>
</table>
Most noticeable about this information is that whereas medical school graduates from the University of Alberta have remained relatively steady as a proportion of all rural physicians (about a third), Calgary has more than doubled the number of medical school graduates choosing rural locations. The number of graduates from outside Canada has grown by over 100 in absolute terms, but is still relatively stable at about half of all rural practitioners. Graduates from other Canadian, non-Albertan medical schools have dropped from 16% to approximately 10% as a proportion of all rural physicians practicing in Alberta.

Recruitment of Rural Physicians

Attracting Physicians to Rural Alberta

In the 1994 “Pockets of Good News” Report, the top five factors that were named as attractive to medical residents when considering rural practice were:

- An on-call rotation of one-in-four or better;
- Harmonious working relationships;
- Professional and personal welcome of a new physician and family;
- Employment opportunities for spouse; and
- Opportunities for professional support and development.

This report stressed the importance of matching what physicians need and want with what communities need and want.

The survey of rural physicians undertaken as part of the 1996 Rural Physician Action Plan Evaluation identified these top five factors attracting physicians to rural locations:

- Challenge of a varied practice;
- Working relationships in the medical community;
- Availability of hospital facilities;
- Special skills for rural practice; and
- Rural lifestyle.

In 2002, the medical residents that the consultants spoke with emphasized the importance of:

- Breadth of practice opportunities;
- Harmonious working relationships;
- Match with the resident’s cultural, recreational and social interests;
- Employment for spouse; and
- Reasonable on-call requirements (no more than one-in-four).

Today’s residents seem to be more focused on lifestyle issues than previous cohorts of residents, although harmonious working relationships with other physicians in the community is ranked as an important factor as well.

Recruitment Patterns in Rural Alberta

Looking at the slow growth of the total number of physicians practicing in each region in rural Alberta masks the true “turnover” of physicians. The table on the following page demonstrates the activity level in each region.
### Table 6 – Movement of Physicians in Rural Alberta, 1987 - 2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1 – Chinook</td>
<td>+7</td>
<td>+5</td>
<td>+7</td>
<td>-1</td>
<td>+1</td>
<td>+4</td>
<td>+2</td>
<td>+6</td>
<td>+4</td>
<td>+2</td>
<td>+4</td>
<td>+3</td>
<td>+3</td>
<td>+9</td>
<td>+6</td>
</tr>
<tr>
<td></td>
<td>-5</td>
<td>-3</td>
<td>0</td>
<td>-3</td>
<td>-4</td>
<td>-10</td>
<td>-6</td>
<td>-2</td>
<td>-10</td>
<td>-6</td>
<td>-8</td>
<td>-5</td>
<td>-4</td>
<td>-3</td>
<td>-3</td>
</tr>
<tr>
<td>Region 2 – Palliser</td>
<td>+1</td>
<td>+4</td>
<td>+2</td>
<td>0</td>
<td>+2</td>
<td>+1</td>
<td>+2</td>
<td>+2</td>
<td>+2</td>
<td>+2</td>
<td>+1</td>
<td>+5</td>
<td>+7</td>
<td>+3</td>
<td>+7</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td>-3</td>
<td>0</td>
<td>0</td>
<td>-2</td>
<td>-1</td>
<td>-2</td>
<td>-2</td>
<td>-4</td>
<td>-4</td>
<td>-2</td>
<td>-4</td>
<td>-2</td>
<td>-4</td>
<td>-3</td>
</tr>
<tr>
<td>Region 3 – Headwaters</td>
<td>+3</td>
<td>+1</td>
<td>+13</td>
<td>-5</td>
<td>+5</td>
<td>+7</td>
<td>+7</td>
<td>+11</td>
<td>+7</td>
<td>+11</td>
<td>-6</td>
<td>+14</td>
<td>-6</td>
<td>+10</td>
<td>+11</td>
</tr>
<tr>
<td></td>
<td>-4</td>
<td>-4</td>
<td>-5</td>
<td>-3</td>
<td>-3</td>
<td>-6</td>
<td>-3</td>
<td>-7</td>
<td>-7</td>
<td>-6</td>
<td>-8</td>
<td>-3</td>
<td>-5</td>
<td>-5</td>
<td>-9</td>
</tr>
<tr>
<td>Region 5</td>
<td>+4</td>
<td>+3</td>
<td>+1</td>
<td>+0</td>
<td>+5</td>
<td>+2</td>
<td>+5</td>
<td>+2</td>
<td>+5</td>
<td>+0</td>
<td>+5</td>
<td>+6</td>
<td>+5</td>
<td>+3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>-6</td>
<td>-6</td>
<td>-4</td>
<td>-2</td>
<td>-4</td>
<td>-2</td>
<td>-4</td>
<td>-2</td>
<td>-6</td>
<td>-2</td>
<td>-6</td>
<td>-2</td>
<td>-4</td>
<td></td>
</tr>
<tr>
<td>Region 6 – David</td>
<td>+11</td>
<td>+10</td>
<td>+8</td>
<td>+8</td>
<td>+16</td>
<td>+9</td>
<td>+9</td>
<td>+6</td>
<td>+8</td>
<td>+10</td>
<td>+9</td>
<td>+18</td>
<td>+16</td>
<td>+10</td>
<td></td>
</tr>
<tr>
<td>Region 7 - East Central</td>
<td>+8</td>
<td>+10</td>
<td>+8</td>
<td>+5</td>
<td>+13</td>
<td>+12</td>
<td>+7</td>
<td>+9</td>
<td>+2</td>
<td>+6</td>
<td>+12</td>
<td>+8</td>
<td>+20</td>
<td>+20</td>
<td></td>
</tr>
<tr>
<td>Region 8 – Westview</td>
<td>+10</td>
<td>+9</td>
<td>+8</td>
<td>+9</td>
<td>+14</td>
<td>+4</td>
<td>+7</td>
<td>+8</td>
<td>+8</td>
<td>+12</td>
<td>+8</td>
<td>+17</td>
<td>+10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 9 – Crossroads</td>
<td>+6</td>
<td>+6</td>
<td>+4</td>
<td>+5</td>
<td>+2</td>
<td>+3</td>
<td>+5</td>
<td>+1</td>
<td>+3</td>
<td>+2</td>
<td>+6</td>
<td>+11</td>
<td>+10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 11 – Aspen</td>
<td>+5</td>
<td>+3</td>
<td>+2</td>
<td>+5</td>
<td>+7</td>
<td>+7</td>
<td>+6</td>
<td>+1</td>
<td>+7</td>
<td>+4</td>
<td>+2</td>
<td>+13</td>
<td>+11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 12 – Lakeland</td>
<td>+22</td>
<td>+14</td>
<td>+14</td>
<td>+16</td>
<td>+10</td>
<td>+12</td>
<td>+7</td>
<td>+11</td>
<td>+9</td>
<td>+7</td>
<td>+14</td>
<td>+15</td>
<td>+10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 13 – Mistiah</td>
<td>+1</td>
<td>+5</td>
<td>+3</td>
<td>+3</td>
<td>+7</td>
<td>+2</td>
<td>+1</td>
<td>+3</td>
<td>+2</td>
<td>+4</td>
<td>+4</td>
<td>+5</td>
<td>+1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 14 – Peace</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
<td>+2</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
<td>+1</td>
<td>+5</td>
<td>+4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 15 – Keewatinok</td>
<td>+4</td>
<td>+2</td>
<td>+1</td>
<td>+0</td>
<td>+1</td>
<td>+2</td>
<td>+0</td>
<td>+1</td>
<td>+2</td>
<td>+5</td>
<td>+3</td>
<td>-1</td>
<td>+1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region Northwestern</td>
<td>2</td>
<td>-3</td>
<td>-2</td>
<td>-3</td>
<td>-4</td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
<td>-2</td>
<td>-3</td>
<td>-1</td>
<td>-1</td>
<td>-3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL Rural Physicians</td>
<td>+83</td>
<td>+78</td>
<td>+85</td>
<td>+68</td>
<td>+91</td>
<td>+70</td>
<td>+62</td>
<td>+68</td>
<td>+64</td>
<td>+64</td>
<td>+60</td>
<td>+91</td>
<td>+135</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** The transfer of Leduc to Capital Health Authority was ignored for purposes of this table.
Table 7 – Source of New Physicians – 1996 to 2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>U of A</td>
<td>14</td>
<td>8</td>
<td>22</td>
<td>17</td>
<td>11</td>
<td>4</td>
<td>76</td>
</tr>
<tr>
<td>U of C</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Canada</td>
<td>9</td>
<td>5</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>6</td>
<td>54</td>
</tr>
<tr>
<td>South Africa</td>
<td>5</td>
<td>15</td>
<td>22</td>
<td>52</td>
<td>41</td>
<td>27</td>
<td>162</td>
</tr>
<tr>
<td>Other Foreign</td>
<td>12</td>
<td>10</td>
<td>9</td>
<td>26</td>
<td>18</td>
<td>14</td>
<td>89</td>
</tr>
<tr>
<td>TOTAL</td>
<td>41</td>
<td>42</td>
<td>66</td>
<td>111</td>
<td>87</td>
<td>53</td>
<td>400</td>
</tr>
<tr>
<td>% Canadian</td>
<td>58.5%</td>
<td>40.5%</td>
<td>53.0%</td>
<td>29.7%</td>
<td>32.2%</td>
<td>22.6%</td>
<td>37.2%</td>
</tr>
<tr>
<td>% Foreign</td>
<td>41.5%</td>
<td>59.5%</td>
<td>47.0%</td>
<td>70.3%</td>
<td>67.8%</td>
<td>77.4%</td>
<td>62.8%</td>
</tr>
</tbody>
</table>

NOTE: New physicians are considered to be those not practicing in Alberta in the previous year. This does not include physicians who may have made inter-regional moves in the previous year (which the previous table does include).

The regional medical directors indicated that to this point, there are enough Canadian graduates to keep up with physician retirements, but not enough to keep up with the need. Given a “demand” for retirement replacements of approximately 30 per year over the next 20 years, recent patterns raise the question of whether this will continue to be true. However, the 20 additional places now available through the Alberta Rural Family Medicine Network should make it easier to meet the demands of retiring rural physicians than in the past. The decreasing numbers of non-Albertan Canadian graduates going to rural Alberta could result in replacement of Canadian-trained retiring physicians with foreign-trained new physicians.

Currently, most regions are in a relatively good position in terms of complement of rural physicians. Most regions are looking at some recruitment at this time, or anticipating a need to replace retiring physicians over the next year, but the greatest need seems to be for specialists for the regional centres, as well as family physicians for some of the regional centres. We heard about a few instances where recruitment for a rural community has been difficult, but the situation appears to be much better than it was prior to the Rural Physician Action Plan-led recruitment drive of a 1998-99. However, as one Medical Director stated, “The situation can change in the blink of an eye.” Many informants stressed the importance of keeping on top of the situation, staying in touch with the physicians, and ensuring that their concerns and issues are dealt with as they arise, rather than waiting until the physician is disgruntled enough to leave the community.

**Rural Recruitment Practices**

*From the Regional Medical Directors’ Perspective*

From the regions’ perspective, the RPAP initiatives mentioned most often as having an impact on recruitment were:

- Matching Signing Bonuses for new Alberta Trainees (some regions also make this available to non-Alberta trained physicians);
- Recruitment Expense Reimbursement Program;
• The Rural Rotations Program for Medical Students and Specialty Residents; and
• The Alberta Rural Family Medicine network – Rural Alberta North and Rural Alberta South.

Virtually all of the rural regions acknowledge a continued reliance on the Part 5 Designation process for recruitment of physicians and expect that the need for Part 5 Designations will not lessen in the foreseeable future. Several Medical Directors expressed concern about the policy of the College of Physicians and Surgeons of Alberta requiring medical graduates from outside of Canada to pass the Medical Council of Canada Qualifying Examination before granting a provisional license. At least two Medical Directors stated that this policy has resulted in potential recruits deciding not to further pursue a move to Alberta. Although they understand the reason for, and in most cases, support the policy change, they feel it may make recruitment of foreign trained medical graduates more difficult.

Physicians in rural practice are significantly involved with the recruitment of physicians to join their practices, generally with regional support and assistance. Recruitment is often done through physicians’ own “networks”. For communities with most or all ‘Part 5’ physicians, especially from one country, this may be a good news/bad news scenario. The positive side of this networking process of recruiting interested physicians is that it provides an opportunity for the local physicians to ensure compatibility with new recruits. The downside, pointed out by some respondents, may be that the existing physicians, by consistently recruiting from their country of origin, may not make sufficient attempts to recruit Alberta or Canadian educated physicians. Many felt that it is important that local medical graduates be able to compete for available positions in rural Alberta.

Several regions have within the region but not connected to the RHA, community physician recruitment committees. The RPAP Rural Consultants are developing a list of RHAs and communities with formalized recruitment and retention committees, key individuals involved and sample resources. Most Medical Directors indicated that there is not as much community involvement in physician recruitment and retention as they would like to see, and the establishment of community physician recruitment committees is one way of involving the community and educating them about the issues relating to physician recruitment and retention. Communities most often become involved when they are experiencing a shortage of physicians to serve the community. Appendix 2, starting on page 36, identifies a number of examples of communities that are involved in recruitment and retention activities.

In most communities, it is the local physicians themselves and their spouses, and hospital administrators that put effort into welcoming new physicians and their families. There are examples across Alberta of communities providing support in the area of physician recruitment by building clinics, making housing available, and otherwise supporting the recruitment of physicians. However, these communities tend to be the exception, and in most cases have become involved because of a problem with recruitment or retention of physicians. To this point, town administrations tend not to become involved in issues relating to physician recruitment and retention, beyond providing some information on the community’s amenities. Some regions, particularly East Central RHA, are working with their communities and have established recruitment committees that also try to stay involved with physicians and their families.

David Thompson RHA has in place an extensive Needs/Impact Analysis process which is used as a hospital medical resources planning tool, and provides information about the impact on
hospital resources of adding a new or replacement physician to the medical staff. The analysis starts with an assessment of community service needs and ensures that new appointments occur within the context of the overall physician manpower plan.

The work that the RPAP Rural Consultants are undertaking in contacting community leaders throughout the province, will undoubtedly result in a much better understanding about the key role that communities can play in supporting physician recruitment and retention. The regional health authority must, of course, be willing to allow the community to become involved, and in fact, welcome this involvement. Municipal leaders feel that they have a responsibility to equally serve all segments of the community, and therefore some are not willing to single out physicians and their families for special support. There are other vehicles to garner community involvement, such as the Chambers of Commerce, local hospital foundations, Community Health Councils, special Medical Services Committees, etc. The RPAP Rural Consultants are finding that many of the communities contacted have not thought much to this point about their role vis-à-vis physician recruitment and retention.

Several regional Medical Directors expressed concerns about what they characterized as ever-increasing inter-regional rivalry when it comes to recruitment of physicians. Some regions are able to offer recruits lucrative incentive packages that are significantly greater than other regions are able to offer. This situation can make recruitment difficult for those regions without the financial ability to match the incentive packages. As well, offering large incentives to new recruits can set up a negative dynamic between those new recruits and older, long-term physicians who have persevered in the area, and who likely didn’t receive an incentive when they came to the community. Similarly, many noted increasing difficulty competing for physicians with regional centres and larger urban centres, and stated that it is critical that the rural areas be able to offer incentives that can’t be matched by larger centres, i.e., on-call payment, in order to maintain a recruitment advantage through clear rural incentive differentiation.

Few Medical Directors mentioned the existence of available support material for rural recruitment. However, the Rural Physician Action Plan has prepared a number of pamphlets, including:

- Tips to Making Recruiting Easier;
- The Importance of Following Up;
- Matching Signing Bonus;
- Welcoming the Physician to your Community; and
- Thumbnail sketches of nearly all of the RPAP Programs.

These pamphlets could provide an invaluable source of excellent information for all stakeholders involved in physician recruitment and retention: physician practices, the RHAs, and for involved communities. Perhaps more needs to be done to make sure that all appropriate stakeholders are aware of these materials.
From the Residents’ Perspective

In discussions with residents who are actively considering rural practice, there was a general feeling that the residents were inadequately trained to undertake rural practice. However, as one resident stated: “You can’t just keep getting more training. At some point you have to make the leap and actually start in rural practice”. This is primarily why residents try to get placements in locations with 5+ physicians: partially, to reduce the on-call, and partially to increase the back-up and support available from more experienced rural physicians.

For residents, attendance at the Rural Physician Action Plan Recruitment Fairs is mandatory, but a number of individuals commented on the extremely poor follow-up by regions or communities afterwards. Specific suggestions made by the residents in terms of effective regional practice included:

- Specific (expenses paid) invitations to residents to visit a community. Having residents “come and see” works well, however, the focus must be on more than the specific business opportunities. The resident and spouse/family need to see the town, get a sense of amenities, difficulties of getting to neighbouring communities, potential for spousal employment, schools, etc. The physicians appreciated the opportunity to visit the community and to meet the physicians with whom they would be practicing prior to accepting the position.

- The financial incentives available upon accepting a position in a rural community are very important to the residents.

- The residents are aware that it is a “seller’s market”, and that they are much in demand. However, few regions follow-up on personal contacts made at the Recruitment Fair with specific letters to the residents at a later point.

Generally, a successful rural placement is the strongest enticement to rural practice. If this is a success, then there is an entrenched desire to return to rural practice. There is strong consensus about the importance of providing opportunities for medical students to experience medical practice in rural communities before they have made the decision about where to practice upon graduation. The Rural Rotations Program and the Rural Family Medicine Residency Program are seen as very useful in achieving more exposure of medical students to the rural stream. Residents from the universities often know little or nothing about rural communities or rural practice, unless they come from a rural background. Seventeen residents are joining the Alberta Rural Family Medicine Network’s Rural Alberta North and Rural Alberta South training units to prepare for practice in rural Alberta. All those interviewed indicated that this is a great initiative, but also acknowledge that it will take awhile for its impact to be felt in terms of increased Alberta graduates working in rural Alberta.

From the Physicians’ Perspective

Without exception, the physicians interviewed indicated that the recruitment incentives offered were instrumental in their decision to accept a position in rural Alberta. Some of the incentives mentioned as important considerations were: expense-paid visit to the community; signing bonuses; help with moving and relocation expenses; start up loans; guaranteed income for six months; housing provided for a period of time; and permission to work in the local hospital so as to minimize overhead costs while establishing the practice. Most of the physicians indicated that the level of support they received was adequate; however, several mentioned that they would
have liked to have received help with finding a house (especially in the smaller communities) and obtaining financing for a home purchase. Others mentioned that they would have appreciated the offer of more financial assistance, perhaps on a pay-back basis, noting that it can be difficult to establish credit when beginning a practice.

Many physicians would have appreciated having available a “primer” on issues like billing processes, hospital privileges, and any local issues that they otherwise have to learn by trial and error, especially in communities with only one or two physicians from whom support can be sought. RPAP is developing an orientation guide for new physicians to Alberta, which may address these issues and concerns.

The majority of the physicians interviewed regarding recruitment practices were international medical graduates and made the point that it would have had a positive impact on their decision to locate their practices in rural Alberta to have been assured that there would be a good “information package” available upon beginning practice in Alberta. Several mentioned that it would have been helpful to have the opportunity to observe, for a couple of weeks, another physician(s) currently working in the practice or community to become familiarized with practice protocols, referral processes, names of drugs (which may be different from their country of training), what support is available to them as they practice, etc. For some physicians, the two-week assessment period helped with the familiarization process, but others felt that a further two weeks observation period required by the College of Physicians and Surgeons of Alberta was needed. Physicians new to the Canadian medical system could benefit from a period of “supervised integration” in medical practice in Alberta (as noted in the Guide for Regional Health Authorities to the Licensing of Physicians in Alberta). However, it seems to be the case that the supervised integration may not be occurring to the degree expected by the College, or required by the new recruits.

The degree to which the physician and family feels welcomed by the community, physicians and local residents alike, is a very important consideration when deciding whether to accept a position in a rural community, especially for those physicians with families.

Several respondents would have liked to have available a video (or perhaps access via a website) showing exactly “what they were coming to”, and including information about both the practice and the community.

The IMG physicians interviewed were asked what they would recommend in terms of promoting rural Alberta practice to their associates in their country of origin. The responses were:

- More promotion within the countries from which physicians are recruited is required. Most of the recruitment is by word of mouth, and physicians indicated that they never heard or saw government-sponsored promotional material. The physicians recommended promoting the fact that housing may be available, that overhead costs are lower, that financial incentives are available, etc.

- Many physicians mentioned that they had experienced problems with the immigration process and hoped that the process could be made easier, more accessible and friendlier. They found it difficult to know exactly what was expected of them and their families.

- Making the Medical Council of Canada Evaluating Examination easier to write by making it available in more centres which would be convenient to those needing to take the
exam. For example, the Medical Council of Canada Evaluating Examination cannot be taken in South Africa.

- Many respondents indicated that the Medical Council of Canada Qualifying Examinations are difficult, especially for older physicians who have been out of the educational system for several years.
- The RPAP physician retention work plan includes retaining an Immigration Consultant to work RHAs and IMGs with immigration issues.

**Retention of Rural Physicians**

**What is “Successful Retention?”**

The Medical Directors and other key stakeholders interviewed for this project were asked to consider what constitutes “successful retention,” that is, what length of time must a physician remain in a community for the recruitment to be considered successful. A few respondents felt that retaining a physician in a community for 2 to 3 years was success. Just less than half of the respondents stated that in their minds, successful retention was three years – just slightly more than the 30 months that Part 5 physicians are given to become fully qualified. Since foreign-trained physicians comprise about 50% of rural physicians, respondents felt that retaining this group beyond the 30 month commitment could be considered successful retention. The remaining half of respondents stated that the physician must remain in the community for three to five years to meet the definition of successful retention. Respondents stressed that if physicians are leaving a community with less than 3 years service, the question needs to be asked why that physician is leaving.

**Retention Patterns**

The database does not allow us to estimate the number of physicians who remained in a region for less than one year, since it is based on a snapshot taken of physician resources in February of each year.

The following table illustrates the retention patterns of all rural physicians who were practicing in Alberta in 1996, including the number of physicians that left in each year. Figures in brackets reflect physicians who left that particular region, but who are still practicing elsewhere in Alberta.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinook #1</td>
<td>56</td>
<td>5(1)</td>
<td>7(3)</td>
<td>2</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Palliser #2</td>
<td>20</td>
<td>1</td>
<td>2(1)</td>
<td>1(1)</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Headwaters #3</td>
<td>85</td>
<td>6(2)</td>
<td>3(3)</td>
<td>5(3)</td>
<td>2(1)</td>
<td>69</td>
</tr>
<tr>
<td>Region #5</td>
<td>38</td>
<td>4(2)</td>
<td>2(2)</td>
<td>1</td>
<td>2(1)</td>
<td>29</td>
</tr>
</tbody>
</table>
Another way of looking at this data follows in the next table. The number in brackets shows the retention rates for physicians.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>David Thompson # 6</td>
<td>81</td>
<td>8(2)</td>
<td>7(3)</td>
<td>4(2)</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>East Central # 7</td>
<td>71</td>
<td>6 (2)</td>
<td>5 (3)</td>
<td>7 (3)</td>
<td>4 (2)</td>
<td>49</td>
</tr>
<tr>
<td>Westview # 8</td>
<td>66</td>
<td>12 (6)</td>
<td>4 (1)</td>
<td>1</td>
<td>3 (1)</td>
<td>46</td>
</tr>
<tr>
<td>Crossroads #9</td>
<td>63</td>
<td>1</td>
<td>3 (1)</td>
<td>6 (2)</td>
<td>5 (2)</td>
<td>48</td>
</tr>
<tr>
<td>Aspen #11</td>
<td>46</td>
<td>6(6)</td>
<td>4 (2)</td>
<td>1 (1)</td>
<td>6 (2)</td>
<td>29</td>
</tr>
<tr>
<td>Lakeland #12</td>
<td>83</td>
<td>9 (2)</td>
<td>11 (3)</td>
<td>6 (4)</td>
<td>3 (2)</td>
<td>54</td>
</tr>
<tr>
<td>Mistahia #13</td>
<td>24</td>
<td>7 (4)</td>
<td>3 (2)</td>
<td>0</td>
<td>3 (1)</td>
<td>11</td>
</tr>
<tr>
<td>Peace #14</td>
<td>13</td>
<td>1</td>
<td>2 (1)</td>
<td>3 (3)</td>
<td>1 (1)</td>
<td>6</td>
</tr>
<tr>
<td>Keewatinok Lakes # 15</td>
<td>15</td>
<td>2 (2)</td>
<td>2 (1)</td>
<td>2(1)</td>
<td>2 (1)</td>
<td>7</td>
</tr>
<tr>
<td>Northwestern # 17</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>671</td>
<td>69 (29)</td>
<td>52 (24)</td>
<td>43 (21)</td>
<td>38 (16)</td>
<td>469</td>
</tr>
</tbody>
</table>

Table 9 – Rural Retention Rates – 1996 - 2001

<table>
<thead>
<tr>
<th>REGION</th>
<th>Base number of MDs 1996</th>
<th>Number of physicians retained up to Jan. 1998</th>
<th>Number of physicians retained up to Jan. 1999</th>
<th>Number of physicians retained up to Jan. 2000</th>
<th>Number of physicians in rural service as of Feb 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinook #1</td>
<td>56</td>
<td>51 (91%)</td>
<td>44 (79%)</td>
<td>42(75%)</td>
<td>40 (71%)</td>
</tr>
<tr>
<td>Palliser #2</td>
<td>20</td>
<td>19 (95%)</td>
<td>17 (85%)</td>
<td>17 (85%)</td>
<td>16 (80%)</td>
</tr>
<tr>
<td>Headwaters #3</td>
<td>85</td>
<td>79 (93%)</td>
<td>76 (89.4%)</td>
<td>71 (83.5%)</td>
<td>69 (81.2%)</td>
</tr>
<tr>
<td>Region #5</td>
<td>38</td>
<td>34 (89.5%)</td>
<td>32 (84.2%)</td>
<td>31 (81.6%)</td>
<td>29 (76.3%)</td>
</tr>
<tr>
<td>David Thompson #6</td>
<td>81</td>
<td>73 (90%)</td>
<td>71 (87.9%)</td>
<td>64 (79%)</td>
<td>60 (74.1%)</td>
</tr>
<tr>
<td>East Central #7</td>
<td>71</td>
<td>65 (91.5%)</td>
<td>60 (84.5%)</td>
<td>53 (74.6%)</td>
<td>49 (69%)</td>
</tr>
<tr>
<td>Westview #8</td>
<td>66</td>
<td>54 (81.8%)</td>
<td>50 (75.8%)</td>
<td>49 (74.2%)</td>
<td>46 (69.7%)</td>
</tr>
<tr>
<td>Crossroads #9</td>
<td>63</td>
<td>62 (98.4%)</td>
<td>59 (93.7%)</td>
<td>53 (84.1%)</td>
<td>48 (76.2%)</td>
</tr>
<tr>
<td>Aspen #11</td>
<td>46</td>
<td>40 (87%)</td>
<td>36 (78.3%)</td>
<td>35 (76.1%)</td>
<td>29 (63%)</td>
</tr>
<tr>
<td>Lakeland #12</td>
<td>83</td>
<td>74 (89.2%)</td>
<td>63 (75.9%)</td>
<td>57 (68.7%)</td>
<td>54 (65.1%)</td>
</tr>
<tr>
<td>Mistahia #13</td>
<td>24</td>
<td>17 (70.8%)</td>
<td>14 (58.3%)</td>
<td>14 (58.3%)</td>
<td>11 (45.8%)</td>
</tr>
<tr>
<td>Peace #14</td>
<td>13</td>
<td>12 (92.3%)</td>
<td>10 (76.9%)</td>
<td>7 (53.8%)</td>
<td>6 (46.2%)</td>
</tr>
<tr>
<td>Keewatinok Lakes #15</td>
<td>15</td>
<td>13 (86.7%)</td>
<td>11 (73.3%)</td>
<td>9 (60%)</td>
<td>7 (46.7%)</td>
</tr>
<tr>
<td>Northwestern #17</td>
<td>10</td>
<td>9 (90%)</td>
<td>7 (70%)</td>
<td>6 (60%)</td>
<td>5 (50%)</td>
</tr>
</tbody>
</table>
This table illustrates that, on average, of the physicians practising in rural Alberta in 1996, approximately 70% have been retained in the same location for at least five years, with 83% staying in somewhere in Alberta.

Looking at retention from a different perspective, the following table shows the length of service in that region of the doctors practising in rural Alberta in 2001. This table also includes the regional centres. (For comparison purposes, for this table, Leduc physicians were not transferred to Region #10, but rather are included in the numbers for Region #9).

Table 10 – Years of Practice in Rural Alberta for Physicians Practising in 2001

<table>
<thead>
<tr>
<th>REGION</th>
<th>#</th>
<th>10+</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinook #1</td>
<td>59</td>
<td>30</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>7.1</td>
</tr>
<tr>
<td>Palliser #2</td>
<td>26</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td>Headwaters #3</td>
<td>105</td>
<td>43</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>12</td>
<td>1</td>
<td>9</td>
<td>7</td>
<td>11</td>
<td>9</td>
<td>6.6</td>
</tr>
<tr>
<td>Region #5</td>
<td>39</td>
<td>19</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>6.8</td>
</tr>
<tr>
<td>David Thompson #6</td>
<td>106</td>
<td>51</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>8</td>
<td>13</td>
<td>13</td>
<td>10</td>
<td>6.5</td>
</tr>
<tr>
<td>East Central #7</td>
<td>86</td>
<td>39</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>17</td>
<td>14</td>
<td>5</td>
<td>6.2</td>
</tr>
<tr>
<td>Westview #8</td>
<td>76</td>
<td>32</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>6.5</td>
</tr>
<tr>
<td>Crossroads #9</td>
<td>70</td>
<td>35</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>6.3</td>
</tr>
<tr>
<td>Aspen #11</td>
<td>58</td>
<td>27</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Lakeland #12</td>
<td>95</td>
<td>42</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>15</td>
<td>10</td>
<td>8</td>
<td>6.4</td>
</tr>
<tr>
<td>Mistahia #13</td>
<td>22</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>6.4</td>
</tr>
<tr>
<td>Peace #14</td>
<td>19</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Keewatinook Lakes #15</td>
<td>23</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5.1</td>
</tr>
<tr>
<td>Northwestern #17</td>
<td>11</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>5.5</td>
</tr>
<tr>
<td>All Rural Alberta</td>
<td>795</td>
<td>351</td>
<td>15</td>
<td>24</td>
<td>15</td>
<td>33</td>
<td>31</td>
<td>58</td>
<td>105</td>
<td>92</td>
<td>71</td>
<td>6.4</td>
</tr>
</tbody>
</table>

From examination of this table, it can be seen that approximately 44% of the physicians currently practising in rural Alberta have been there for more than 10 years, with 54% practicing in rural Alberta for more than 5 years. Generally, the further north you look in Alberta, the lower the average length of time in rural practice. On average, physicians currently practising in rural
Physician Retention in Rural Alberta  March 30, 2002

Alberta have been practicing in rural Alberta for at least 6.4 years. These data also reflect the major influx of new physicians in the 1998 recruitment blitz. These physicians have now been in rural Alberta for 3 years. Only time will tell how long this cohort will remain in rural practice.

Generally, regions feel that if a physician can be retained for more than 5 years, the physician is probably committed to long-term rural practice.

Physicians Leaving Rural Practice

There are a number of different reasons why physicians leave rural practice, some of which are within the control of the rural community/region, and some of which are not. In many cases, these can be considered to be “trigger” factors, which together with a general level of dissatisfaction are sufficient to cause a physician to decide to leave rural practice.

“Uncontrollable” Reasons for Leaving

In most cases, the “uncontrollable” factors that cause a physician to leave rural practice are more a result of a strong attraction for another form of medical practice or a change in life plan. Thus, in many respects, from the physician’s perspective, these factors are not negative in any way, but rather a positive move in a longer term life plan.

- **Planned retirement** – as part of ageing, individuals make plans for full or partial retirement. For a busy rural physician, this could take the form of a planned reduction in work volume or type, a move to a “retirement community” with limited practice expectations, a reduction in privileges and elimination of on-call responsibilities, or complete retirement to a non-rural area, etc.

- **Return to full-time school for additional specialist training** – many physicians choose to leave rural practice as their interests in specific areas of practice blossom. Additional training in specialist areas can only be obtained in urban (primarily Edmonton and Calgary) locations. The resulting specialist training often cannot be justified in a rural location (e.g., dermatology, trauma surgery, forensic medicine, etc.), and the physician will never return to rural practice. In other cases, for more general specialities (internal medicine, general surgery, ob-gyn, anaesthesia, etc.), it may be possible for the region to negotiate a return to rural practice after the specialist education is complete.

- **Completion of specific financial goals** – many residents indicated that rural practice is sometimes a stage where a young physician can make significant money in a short period of time. That is, some graduating physicians choose rural practice specifically for a short (three to five year) period in order to gain as much financial incentive and on-going fee-for-service and on-call income as possible. This allows the physician to pay off student loans and get the financial grounding to open up a practice in a more desired (usually urban) location, once the burden of debt has been lifted.

- **Changes in spouse’s/children’s needs** – as families age, the needs of the physician’s spouse and children may also change. For example, children may require special schooling as they get older, or a stay-at-home spouse may wish to return to work as the children enter school. At a certain point, the amenities of the rural community may no longer be a good fit
with the needs of the family, triggering a move to a different community which will more closely meet the overall families needs.

- **Changes in family health** – the health needs of the physician, the physician’s spouse, children and extended family can all have an influence on the physician’s ability to remain in rural practice. Sometimes, a move is required in order to care for an ageing parent, or to obtain specialized medical care for an ailing spouse or child. And, sometimes the physician’s health does not allow for continued rural practice, which can be physically demanding with long hours and on-call responsibilities.

Although the region/community can do little to influence the physicians’ decision in these areas, the benefits of a close working relationship between the physician and the region can result in these normal life changes for the physician becoming a part of the on-going regional manpower planning process.

**“Controllable” Reasons for Leaving**

Whereas this first set of reasons for leaving rural practice is a result of a physician or family circumstances, there are other changes that can actively operate to “drive a physician away” from a rural area. These changes are often, at least to some degree, within the control of the region/community and include:

- **Changed working environment** – Physicians want to know that they will be provided with the “tools” needed to support their work, i.e., well appointed offices, access to operating facilities, admitting privileges at the local hospital, etc. Changes in any of these factors may decrease the physician’s desire to remain in the rural location.

- **Changed job requirements** – In many cases, the job requirements of medical practice in a specific area are a direct result of the number of physicians in the local area. There are two primary aspects to this. First, there must be a reasonable on-call schedule, no more than one-in-four. The reduction in on-call responsibilities and the locum programs have made a difference to the level of satisfaction of physicians. Some still feel the on-call obligations are too onerous, but for the most part, the payment and the efforts at reducing the amount of time physicians are on-call have been effective in reducing the discontent with this aspect of rural practice. Secondly, the overall number of physicians in a rural area affects the level of effort and income generated by the local physician. While too many physicians in a particular area can make a practice financially uneconomical, too few physicians can lead to overwork and burn-out. Thus, a rural area that is chronically over-staffed or under-staffed by physicians will result in increased dissatisfaction on the part of physicians in that area.

- **Changed job satisfaction** – The ability to practice in a varied and challenging environment is important to many rural physicians. Any changes to the physicians’ ability to use their special skills may negatively influence their satisfaction with on-going rural practice. For example, if the local anaesthetist cannot be replaced, the local surgeon or obstetrician may be forced to relocate if they wish to continue to use their special training.

- **Changed job relationships** – A primary driver for physician satisfaction seems to be a positive relationship between the physicians, the RHA, and hospital staff in the local area. A welcoming and collegial atmosphere is an important consideration for a physician debating whether to stay in a particular community. A physician might initially accept a position where he/she senses some tension or lack of welcome, but that physician will look around for a
more collegial medical community before long. There must be a “good match” between the physicians within the practice, and between the physician (and the family) and the community.

- **Changed ability to meet professional needs** – On-going CME is important to most rural physicians. However, the ability to take advantage of CME opportunities is coupled with the ability to call in a locum to support time off for continuing medical education and skills training, and for time with the family. Changes in the ability to “get away”, either for CME or for family holiday time, can negatively influence a rural physician’s willingness to stay in a rural area.

By careful planning, and involving the local physicians in the decision-making process, many of these factors can be managed in such a way to ensure that they do not become a dissatisfying “trigger” for rural physicians.

**Retaining Physicians in Rural Alberta**

Although the information in the previous section provides information about why physicians leave, it is less clear why they stay. As one Medical Director pointed out, “by the time you find out that are planning to leave, it is too late”. Different stakeholder groups emphasized different aspects of rural practice or different incentive programs as being important in encouraging a physician to remain in the rural community.

**From the Regional Medical Directors’ Perspective**

Those who were interviewed for this project were relatively consistent in stating that one of the most important elements ensuring retention of physicians relates to the need for both the recruiting group and the prospective physician to “do their homework” before deciding whether to offer, or to accept the offer of practice in a rural community. A good “match” up front makes it far more likely that the physician will stay a relatively long time. The regional Medical Directors are convinced of the importance of a “pre-selection” process which brings the physician interested in working in the region to the selected community to meet colleagues, see first-hand the work environment and the community and its amenities, and allow an opportunity for both parties to assess compatibility. This process minimizes dissatisfaction after the physician/family has relocated and tends to smooth the way for better and faster integration into the practice and the community.

Most regional Medical Directors feel that the most important commodity they can provide physicians is support for continuing education and training that the physicians want to pursue, and ensuring, to the greatest extent possible, a challenging and varied work experience.

There is also a recognition by the regional Medical Directors that it is important to foster and maintain a collegial atmosphere within the region to retain physicians. There is neither agreement on how this is best accomplished, nor any consolidated plan across all the regions to do this. Many have in place, or are planning, various forms of recognition for physicians, such as award nights or other events. The RPAP is planning a process to recognize all rural physicians.

One northern regional Medical Director noted that there must be a greater appreciation of the degree of isolation for physicians in the remote parts of the province. The region is proposing to
supplement on-call payments, and suggested that an isolation payment based on distance of the family physician from specialist support should be considered.

Physicians have indicated that they like to have input into, and feel part of planning and decision-making processes within the regional health authority. Some Medical Directors indicated that establishing a process to include physicians in administrative roles can be difficult because physicians are "unattached" to the region in the sense of an employer-employee or contractual relationship. Many of the Medical Directors are recognizing the importance of developing a stronger sense of relationship with the physicians and doing what they can to foster a good working atmosphere across the region.

Regional Medical Directors, almost without exception, stated that the Rural On-Call Remuneration Program has been the most effective RPAP initiative influencing rural physician retention. The indication is that physicians seem to be more content in rural practice since the initiation of the on-call payments. This was confirmed by an evaluation of the Rural On-Call Remuneration Program completed in 2001.

Many of the Medical Directors mentioned the importance of satisfied and happy spouses and families to retaining physicians in rural communities, and have high expectations that the Rural Physician Spousal Network will have success in its work towards supporting physicians' spouses. They recognize that the initiative is relatively new; however, most feel that it has tremendous potential to provide much needed support to spouses through the localized area support networks and other activities that are planned. Some informants, however feel that that this initiative is not likely to have a great impact, and one wondered whether male spouses will be included.

The Rural Locum Program was consistently mentioned as a positive influence on physician retention. More than one informant for this project mentioned that they find Brenda Gilboe, of the AMA Rural Locum Program, very helpful and supportive to the regions in terms of recruitment and retention of physicians. Other RPAP supports for physicians mentioned as having a positive impact on retention are the Skills Brokers and the Enrichment Program. Generally the RPAP initiatives and programs are considered to be innovative and working in the right direction.

The regional Medical Directors, for the most part, would like to see more support and involvement from the local communities in issues relating to physician recruitment and retention. Some regions are supportive of community involvement, but most have not, to this point, actively pursued community involvement or support. The work of the RPAP Rural Consultants in meeting with community groups will no doubt foster more interest on the part of communities. It will be important for RHAs to have a consolidated plan to work with communities so that situations don’t arise where the region may be competing against a particular community for physicians.

**From the Residents’ Perspective**

Residents in particular highlight the importance of an effective and collegial relationship within the local medical community as critical to ensuring retention in the community. The largest single factor mentioned that drives residents away from a community is feuding between clinics or between clinic and hospital in a particular rural community.
Another, more time limited factor for many residents is the long-term potential for a satisfying personal, social, recreational and cultural life in the rural community. Single residents in particular, are willing to “take a chance” for a year or two, but if social opportunities with other single people do not transpire, the resident will move elsewhere. The potential for meeting and dating is seen as a major drawback for long-term retention in a rural community. As one resident stated, “you can only go to the city for a date for so long, then you want someone closer to home”. Clearly, social isolation is a major factor for young, single, Canadian trained doctors.

Specific suggestions made by residents that would influence them to stay longer in a rural community included:

- Guaranteed paid vacation (or at least coverage of overhead during the time away) with locum provided;
- Financial incentives or an indexed minimum salary guaranteed for long-term retention in the community;
- Bursary arrangements that start during the residency period to provide support while the resident is still in school (preventing further growth in student loans) and/or direct payment for student loans from the rural region; and
- Support for development of special skills through 24/7 on-line telemedicine experts throughout the province (equivalent to an attending physician in hospital).

**From the Rural Physicians’ Perspective**

The physicians put a lot of emphasis on the importance of the degree to which they feel welcome as well as the importance of a collegial working atmosphere to their decision to stay in a community. Almost every one of the physicians interviewed indicated that they and their family were welcomed by both the community and by colleagues and that they plan to stay in the community in which they are now practicing. Those that don’t plan to stay will be leaving to pursue educational and training opportunities. One physician will be returning to her native country because she is unable to bring her spouse into Canada. Almost without exception, the rural physicians feel welcome and respected in their communities.

One issue mentioned by many physicians is the need for more support in securing employment or contacts that might lead to employment for spouses. In some small communities, the only employment that seems possible for spouses is to work in the physician’s office. Support for obtaining employment for the physician’s spouse is an important support that can be provided that doesn’t cost money, or require additional resources. Respondents commented over and over again that if the spouse isn’t happy, there is a great likelihood that the physician will leave the community. Family contentment with the community is a critical factor in retaining physicians. Families that are met with a warm welcome, offers of support, and assistance in locating employment for the spouse if desired are more likely to want to stay in that community. On-going support is also important. Physicians and their families who become involved in community activities, sports, social clubs, etc. and thus develop a commitment and attachment to the community are more likely to stay for longer periods of time. The Rural Physician Spousal Network, in collaboration with the AMA’s Physician and Family Support Program, is beginning a process of increasing the support for spouses of rural physicians.
There must be a demonstrated ability for the physician to meet his/her income expectations over time. Although most physicians recognize that it might take awhile to build up a practice, they expect that they will be earning what they expected (or have been led to believe would be the case) within a reasonable timeframe. It is important that income expectations not be overstated in the recruitment process. In some cases, physicians are provided a six-month income guarantee by the RHA.

Many rural physicians had specific suggestions that would make rural practice more attractive in the long-term:

- Many rural physicians mentioned that a sabbatical program for rural physicians would be welcome, although they recognize the difficulty in establishing such a program.

- Some mentioned that a “retention bonus” might be considered for long-term rural physicians.

Physicians also feel that the Rural On-Call Remuneration Program and the Rural Locum Program have made considerable impact on the satisfaction of rural physicians. These programs support additional time to spend with family and breaks from the practice for holiday or continuing medical education. The RPAP Recruitment and Retention Action Plan has as one of its components, a plan to pilot an incentive program for longer-term rural physicians, with an emphasis on those in more remote areas.

**Involving the Community**

Five individuals who chair community physician recruitment committees were interviewed for this project. They represent a variety of communities in a variety of regions across the province. Four of the committees were “creatures” of the town councils. One of these committees operates under the council’s Health and Wellness Foundation, another as a Medical Services Committee, and two other committees also involve communities from the immediate surrounding areas. The fifth committee is a Chamber of Commerce committee.

The length of time that these five committees have been operational varies from 2 years to more than 20 years. No terms of reference could be provided for any of the committees; however there may have been some developed at some time during the life of the committees. The number of members involved in the five committees ranges from three to 12.

In all but one case, the committees were initially formed to deal with situations of physician shortages within the communities. In the other case, the committee was initially formed to support a new Board of Directors that had been appointed, and since has become involved in physician recruitment and retention matters. One of the five committees is presently trying to recruit two physicians into a community that has been covered through the locum program since two physicians left at the same time. The first individual recruited did not stay, and the community is starting the recruitment process all over again. Another community has been stable for about 9 months, but had been covered by the locum program for about 18 months prior to the last recruitment. The other three communities plan to recruit at least one physician in the next year or so.

None of the committees have a formal connection with the RHAs. The Chairpersons interviewed indicate that they do not have much contact with the RHAs. They do get support for their recruitment efforts when needed for recruitment of Part 5 physicians, and often the RHAs do
have a package of incentives that can be offered to new recruits. One Chairperson indicated that the regional Medical Director had not been convinced that the community could support another physician, but the community went ahead anyway. In that case, the newly recruited physician set up a weekly clinic in a close by community, thereby expanding his patient base. For the most part, it seems that the RHAs are reasonably supportive of the community committees.

Often additional incentives for the physicians are available because of fundraising and other work done by the committee. Some of the incentives that have been provided through the committees have been significant. The financial incentives have been as high as $60,000 to $80,000. In one community, a contractor built a clinic for the physician, with a guarantee of at least three years of service. Most of the communities have provided housing as well as some support for the clinic. In one case, the clinic had to be completely furnished and equipped, including computer equipment, and supplies, right down to forms, were provided. The Chairperson commented that the outgoing physician had never complained about the lack of amenities, but she was astonished that he had stayed as long as he did.

One of the issues that the communities face once a physician(s) have been found for the community is encouraging those residents who have gone elsewhere for medical care, to bring their “business” back to the local physician. This can be important in terms of ensuring a reasonable income for the new physician. In one community, a plan for an awareness/publicity campaign to let residents know that there were now physicians in the community was not supported by the physicians and was dropped. The two new physicians felt that advertising was not appropriate for their professional status. Another community was pleasantly surprised to find that many of the local residents did bring their health care business back to the community once a physician was recruited.

As mentioned earlier in this report, another issue that recruitment committees often face, particularly in the smaller communities, is the lack of suitable employment for the spouses of physicians. This lack of opportunity can be a real drawback to recruiting physicians whose spouses want to work, particularly in a professional capacity.

The hallmark of the community committees seems to be their enthusiasm, their ability to bring a number of parties onboard in support of physician recruitment and retention, and their willingness to do whatever it takes to ensure there are physicians to serve the community. Several mentioned plans for community appreciation events for the physicians. At least two of the community representatives volunteered, without prompting, to share what they have learned with other communities that may want to start a physician recruitment and retention committee. These five groups demonstrate many “best practices” and it is hoped their experience and expertise can be put to use.

**Physician Recruitment and Retention Initiatives in Other Provinces**

Five provinces provided some information on physician recruitment and retention initiatives. A brief summary of the information is provided here. For more details, see Appendix 1, page 30.

**British Columbia**

B.C. currently has a number of initiatives in place, under the Physician Recruitment and Retention Program (PRRP), many of which are similar in nature to those of the Alberta Rural Physician Action Plan. The PRRP program provides funding for recruitment and retention and
on-call service in rural and small urban communities, with the exception of a retention premium for general practitioners and specialists, which Alberta currently does not offer. Some of the components of the B.C. program are: retention premiums, signing bonuses, payment for on-call services, enhanced CME funding and support for advanced practice and post graduate training. There are a number of other programs and initiatives, as well, mostly designed to attract physicians to rural and remote areas of the province. Some of these are Emergency Medical Coverage Program, Subsidiary Agreement for Physicians in Rural Practice, and research into issues related to Advanced Practice Nurses.

B.C.’s Rural Health Office has developed a number of “new era” commitment relating to rural and remote health including: a 10 year human resource plan that addresses critical skills and staffing levels for underserved areas designed around training, recruitment and retention of physicians, nurses and specialists, and other health care professionals; increasing the number of residency positions and training space for and recruitment of foreign trained physicians; the development of a Rural and Remote Training program and forgivable student loans with commitment of return service; and increased locum support for rural physicians. It is not known how the current budget restraints in B.C. will impact these plans.

**Manitoba**

In December 2000, the Manitoba Department of Health implemented The Manitoba Action Plan for Rural Physician Retention to improve retention of physicians in rural communities. Many of the initiatives within the Plan are modelled to some degree on The Alberta Rural Physician Action Plan. The main components of the Manitoba Action Plan are: to increase the intake of students from a rural background into medical school; increase rural training opportunities for undergraduate medical students and for residents in Family Medicine and medical specialities; restructure rural CME to provide advanced skills training programs for rural physicians; and ensure coordination between medical education programs and community needs. Other programs offer incentives/grants for physicians interested in practicing in under serviced areas of the province.

**Ontario**

Ontario has a number of programs and initiatives related to rural physician supply and retention, including:

- Recently announced plans to increase medical school enrolment by 30% in the province;
- The establishment of a Northern Medical School to train medical professionals to practice in Northern Ontario. Beginning in 2004, the school will admit 55 students per year;
- Rural and Northern Ontario Medical Training Programs to train medical students and residents at teaching hospitals in Northern Ontario to give them experience and skills required to practice in a rural environment after graduation;
- Grants to rural hospitals to support on-call funding;
- Financial incentives to physicians who locate in northern communities designated as underserviced;
- A retention bonus paid at the end of each year in which physicians practice in Northern Ontario;
- Free tuition for final year medical students and residents in exchange for three or four year return of service commitments; and
• A program to recruit 106 new Nurse Practitioners to address the health needs of rural and underserviced areas.

**Newfoundland**

Newfoundland's Resident and Medical Student Practice Incentive Program offers a financial incentive to 4th year medical students and 1st and 2nd year residents who agree to practice in an area of need within the province. Other programs provide bursaries to specialist residents who agree to practice in an area of need after completion of training. The province offers retention bonuses to salaried physicians practicing in rural and remote areas. The rate of the bonus depends on the location of practice within the province, but varies from $2500 after 12 months of service to $36,000 after 36 months of service.

**New Brunswick**

New Brunswick offers location grants of up to $25,000 to newly recruited family physicians and up to $40,000 to specialists who agree to practice in hard to recruit to areas, in return for a guarantee of five years of service. Another program provides financial support in the form of residency training for students who are unable to obtain a residency position or entry to the preferred speciality, and for foreign medical graduates to obtain licensure. Again, the program requires a guarantee of return service.

**RPAP's Work Plan for Retention of Rural Physicians: 2001-2002 and Beyond**

It should be noted that many of the issues identified in this report are being addressed by the RPAP as part of its retention work plan, “Retention of Rural Physicians: An Action Plan for 2001-2002 and Beyond”.

The Rural Physician Action Plan's first three-year business plan focused on consolidating the gains from the RPAP’s 1998-1999 recruitment drive. It introduced improvements to rural medical education (the rural stream) and advanced skills acquisition for family physicians (RPAP Skills Brokers). In early 2001, the focus of the RPAP moved towards retention. “Retention of Rural Physicians: An Action Plan 2001 – 2002 and Beyond” was developed by the RPAP through a consultative process. The new retention work plan includes these priorities:

- Community – encourage and help rural communities to develop physician retention plans.
- Family/Lifestyle – increase support for rural physicians and spouses of rural physicians through programs such as the Rural Physician Spousal Network (RPSN) and collaboration with the Alberta Medical Association’s Physician and Family Support Program.
- Professional – develop community-building processes among physicians to make practice more collegial and less onerous. Pilot an incentive program for longer-term rural physicians, with an emphasis on those in more remote areas.

The specific initiatives that the RPAP team has implemented or is currently planning, in relation to these stated priorities and to address other issues that have been raised as impacting rural physician retention are:

1. Two Rural Physician Consultants, one for the northern part of the province and one for the southern part of the province, have been retained to work with the RPAP team. These
individuals are working collaboratively with physicians, rural health authorities and community representatives to address rural physician recruitment, retention and training issues. The consultants are developing a retention framework for rural physicians to offer as a “toolkit” to RHAs and communities.

2. The RPAP Skills Brokers, now in the second year with the RPAP, continue to assist rural physicians obtain the skills their communities require, to upgrade existing skills or to complete assessments as required by the College of Physicians and Surgeons.

3. The Alberta Rural Family Medicine Network’s training units (Rural Alberta North and Rural Alberta South) will have the first group of 17 residents join the new rural-based Family Medicine residency training program. These individuals, from throughout western Canada, will spend the next two years in the regional centres and in a number of rural communities as they prepare for practice in rural Alberta.

4. The Rural Rotations for Medical Students and Family Medicine and Specialty Residents provides experience and exposure to rural medical practice.

5. The Rural Physician Spousal Network (RPSN) is facilitating the development of area support networks throughout Alberta, as a way of getting more spouses involved and or providing peer support. The RPSN is guided by an Advisory Committee, and will work collaboratively with the Rural Physician Consultants to meet the objectives set for the Network.

6. The RPAP web site has been revamped and new promotional material has been developed.

7. RPAP orientation guide for physicians new to Alberta. This is being developed with input from the College of Physicians and Surgeons and other stakeholders.

8. RPAP physician/community database is being developed.

9. An immigration consultant is being retained to assist the Regional Health Authorities and physicians with immigration issues.

10. Plans are underway for the establishment of local/RHA liaison contacts throughout the province.

11. A Rural Physician Award which would recognize all rural physicians.

Summary and Conclusions

The data presented in this report demonstrates a number of key factors:

- Recruitment continues to be an on-going necessity for rural regions. The age distribution of current rural physicians indicates that approximately 30 physicians per year will be retiring for the next 20 or so years. It is likely that there will be insufficient Alberta-trained physicians to meet this demand, although the 20 additional spaces coming on line through the Alberta Rural Family Medicine Network should ameliorate this situation somewhat.

- The bulk of new physicians recruited to rural regions are foreign trained (77% of new recruits in 2001), and likely to remain so.
• On average, of the physicians practising in rural Alberta in 1996, approximately 70% have been retained in the same location for at least five years, with 83% staying in somewhere in Alberta.

• Approximately 44% of the physicians currently practicing in rural Alberta have been there for more than 10 years, with 54% practicing in rural Alberta for more than 5 years. Generally, the further north you look in Alberta, the lower the average length of time in rural practice. On average, physicians currently practicing in rural Alberta have been practicing in rural Alberta for at least 6.4 years. These data also reflect the major influx of new physicians in the 1998 recruitment blitz. These physicians have now been in rural Alberta for 3 years. Only time will tell how long this cohort will remain in rural practice. Generally, regions feel that if a physician can be retained for more than 5 years, the physician is probably committed to long-term rural practice.

Recruitment to rural practices does not appear to be a major problem at this time, although most regions are currently, or anticipate in the near future, recruiting to one or more positions. There are pockets of the province where recruitment has been difficult. Part 5 Designations still play a large role in the recruitment arena, and will continue to play a key role in ensuring physician supply in rural Alberta for the foreseeable future. Alberta medical school graduates taking on rural practices will almost be able to keep pace with retirements, but not with the growing need for rurally-based physicians. The bigger problem appears to be the ability to fill specialist vacancies in the regional centres. The reduction of on-call responsibilities, in most cases, to no more than one-in-four, has made rural practice more acceptable for physicians and their families.

From the information gathered for this report, it seems that this is a time to consolidate the gains and successes of the past few years in terms of physician recruitment and retention and to continue to enhance the processes and supports that attract physicians to rural practice. The Rural Physician Action Plan has a comprehensive Action Plan to guide their work over the next year, and many of the issues and concerns that have been raised will be addressed as the plan is implemented. In addition, more information should be made available relating to Immigration’s relatively new policy relating to allowing spouses of physicians recruited from other countries to work, if work is available. This policy does not seem to be well known among those who recruit physicians.

The stakeholders interviewed for this report express a great deal of hope that programs like the Alberta Rural Family Medicine Residency program and the rural rotations for medical students and family medicine and specialty residents will result in greater interest on the part of local medical school graduates in establishing their practices in rural Alberta.

However, there appears to be a lack of coordinated, concerted and sustained effort relating to rural physician retention. A planned effort must involve all the key players, including communities, RHAs, and physicians working collectively together. No one party alone, including the RPAP, can be successful at increasing the retention rate of rural physicians. Communities and RHAs in some cases haven’t seen the need for communities to become involved – yet an important consideration for physicians in deciding to locate in a rural community relates to attributes of the community, including opportunities for the physician and family, welcoming attitude by the community and continued involvement to ensure that the family is not isolated, etc. Current RPAP efforts directed at retention seem to be moving in the direction of getting all the key players involved (physicians, families, spouses, RHAs, communities). Time and evaluation will demonstrate their long-term effectiveness.
More work is required to support communities and RHAs in understanding the role communities can play in physician recruitment and retention. It is important that local recruitment committees (or the group that does recruitment for a community) stay in touch with physicians and their families after recruitment. Families, particularly, may need the ongoing support from, and connection to, the community. Those who are recruiting physicians must plan for, and follow through with, better and more consistent contact with prospective applicants after job fairs or any other show of interest by physicians in locating in community.

It is important that regions foster a collegial atmosphere within the physician community, and between the communities and the physicians. Physicians and many of the RHAs realize that this is an important consideration in ensuring physician satisfaction. In addition, physician appreciation events/dinners/evenings, which include spouses and or families, are a way of demonstrating the value of the physician to the community.

This review and update of recruitment and retention practices for rural physicians has emphasized one key consideration: Encouraging physicians to choose and stay in rural Alberta is the responsibility of many individuals and organizations. No one party or stakeholder can ensure that a rural physician will choose to stay in a rural community for a significant period of time. All of the following groups have a critical role to play in ensuring successful retention of rural physicians, including:

- Local medical practitioners;
- Hospital and other facility staff;
- Community leaders and the general public;
- The Regional Health Authority; and
- The Rural Physician Action Plan.
APPENDIX 1 – RECRUITMENT AND RETENTION OF RURAL PHYSICIANS IN OTHER PROVINCES

Five provinces provided some information on recruitment and retention programs.

**British Columbia**

British Columbia’s Rural Health Office has developed these “new era” commitments relating to rural and remote health:

1. Develop a 10 year human resource plan that provides for the training, recruitment and retention of physicians, nurses, specialist and other health care providers in each area of the province and that addresses critical skills and staffing levels for underserviced areas.
2. Establish a Rural and Remote Health Initiative to ensure all families get the care they need, where they live and when they need it.
3. Increase the number of residency positions and increase training space and recruitment of foreign trained physicians.
4. Develop a Rural and Remote Training program and provide forgivable student loans to students attending accredited nursing and medical schools provided they practice for five years in underserviced areas.
5. Introduce a program that provides financial assistance and travel assistance to health care providers currently practicing in rural/remote communities who want to upgrade skills and training.
6. Increase locum support to relieve pressure and reduce workloads, to enhance health care professionals’ quality of life.
7. Develop a travel assistance program to reduce rural patients’ transportation and lodging costs to receive treatment that is not locally available.

B.C. currently has the following rural and remote health programs in place:

1. **Physician Recruitment and Retention Program (PRRP)** – This program provides funding for recruitment, retention and on-call service in rural and small urban communities. The program offers premium incentives to enhance the supply and stability of physician services in rural and small urban communities throughout the province. The Health Authorities are able, through this program, to:
   - Provide retention premiums for general practitioners and specialists;
   - Offer $10,000 signing bonuses to new doctors recruited by health authorities;
   - Provide payments to general practitioners and specialists for on-call services;
   - Provide enhanced CME funding; and
   - Support physician advanced practice and post graduate training.

2. **Recruitment of Foreign Trained Physicians** – This program assists the Health Authorities recruit foreign trained doctors to practice in rural and remote communities. The program sets out specific criteria for the Health Authorities to follow to enable them to recruit new physicians.

3. **Emergency Medical Coverage Program (EMCP)** – The purpose of this program is to provide residents within Northern Isolation Communities (NIA) with 24-hour access to
physician services and to encourage the retention and recruitment of physicians in NIA communities. Communities are designated as NIA communities to be eligible for EMCP funding. EMCP is offered in return for guaranteed physician availability such that the people of the community have access to physician services outside regular office hours. The physicians, the health authority and the community will determine the requirements for physician availability. The program is basically an alternative method to fee for service of paying physicians. Under the non-FFS option, GPs choose not to bill fee-for-service during emergency coverage hours and thereby receive a larger hourly amount for time spent providing emergency medical coverage. This is similar to Alberta’s on-call program, but has more options for physicians, such as a combination of FFS and an hourly rate. The program payments vary, depending on the status of the community (hospital or no hospital), and on the qualification of the physician (GP specialist). The detailed payment schemes have been provided to David Kay, Program Manager, RPAP.

4. **Subsidiary Agreement for Physicians in Rural Practice** – BCMA and the Ministry of Health signed the Subsidiary Agreement for Rural Physicians, the purpose of which is to enhance the availability and stability of physician services in rural and remote areas of British Columbia by addressing some of the uniquely demanding and difficult circumstances affecting the provision of services by physicians. Programs under this agreement include:

- The Northern and Rural Locum Program established to assist physicians practicing in small communities to secure subsidized vacation relief. Physicians may access up to 28 days annually in 5 day minimum blocks.
- Rural Undergraduate/Post Graduate Specialty Training through which the government will fund a budget of $1,000,000 to support and facilitate the training of physicians in rural practice including the Special Skills Program for Rural Physicians, a Re-entry Program and increase the rural training programs for physicians.
- The Northern Isolation Travel Assistance Outreach Program (NITAOP) provides funding for general practitioner services and provides a travel time honorarium for general practitioners and specialists travelling to small and rural communities.
- The Rural Health Video Network Link Project, the purpose of which is to evaluate the feasibility and cost effectiveness of videoconferencing technology for the purposes of clinical consultation and health professional education in rural BC.
- The Rural Health Education Action Plan has a budget of $1 million for rural education and training. The goals of the Plan are to increase the number of students likely to take up rural practice by increasing the exposure and opportunities to practice in rural communities for medical students and residents; to increase the support to rural physician teachers; to increase training for established rural practitioners and to facilitate specialty re-entry and enhanced training opportunities for existing rural physicians.

6. **Advanced Practice Nurse (APN)** – this is a research project designed to obtain data to support decision-making regarding new nursing roles and service delivery models in BC. The project is co-sponsored by the Registered Nurses Association, the University of Victoria, the Capital Health Region, and the Ministry of Health Planning.

7. **BC HealthGuide Program** is designed to deliver reliable health information and advice to individuals in their own homes. The BC HealthGuide Handbook provides information on over 190 common health concerns including prevention, home treatment options and advice on when to seek professional help. The NurseLine offers 24 hour toll-free access
to registered nurses trained to provide confidential health information and advice. BC HealthGuide Online links home computers and public Internet sites to a comprehensive and current web site offering authoritative, practical health information and advice on over 2500 topics, tests and procedures.

**Manitoba**

In December 2000, the Department of Health for Manitoba announced The Manitoba Action Plan for Rural Physician Retention as a component of an overall physician resource plan. The goal of the Action Plan is to improve retention of physicians in rural communities by increasing rural training opportunities in medicine for students, residents and rural physicians. The main goals of the Action Plan are:

- Increase the intake of students from a rural background into medical school.
- Increase rural training opportunities for undergraduate medical students.
- Expand rural training opportunities for residents in Family Medicine as well as medical specialties.
- Restructure rural CME to provide advanced skills training programs that will assist rural practitioners to acquire knowledge and skills needed to meet the health needs of their communities.
- Infrastructure support to ensure coordination between medical education programs and community needs.

One component of the plan is the Medical Student/Resident Financial Assistance Program (MSRFAP) which provides financial assistance to Manitoba medical students and graduates who want to practice medicine in an underserviced area of Manitoba. The educational component of the plan is the educational assistance option which assists physicians during their medical training by making available up to three conditional grants totalling $50,000 for eligible students pursuing a family medicine career, and up to four conditional grants totalling $70,000 for eligible students pursuing a specialty. Recipients are expected to return one year of service in Manitoba (which may include an underserved area) for each grant received. About 150 students and residents are taking part in the program, in its first year.

Through the Underserviced Area Practice Assistance Option, a grant of $15,000 may be available to eligible physicians who are interested in practicing in an underserviced community or area of need. Recipients are expected to return one year of service in an underserviced area.

The Action Plan for Rural Physicians has only been recently implemented, and it is too early to determine the success of the initiatives.

**Ontario**

Ontario has several programs designed to address physician supply, distribution and retention issues:

1. *Medical School Enrolment* – Ontario announced plans earlier this year to increase medical school enrolment by 30% in the province.
2. **Northern Medical School** – As part of the strategy to educate medical students and physicians in under-supplied communities, the government is establishing a new medical school in Sudbury with a clinical education campus in Thunder Bay. This medical school will train medical professionals to practice in the Northeast and the Northwest, making use of “e-learning” technology to encourage physician to learn and live in northern Ontario on a long-term basis. Beginning in 2004, the school will admit 55 students per year, with the goal of bringing physicians to northern Ontario and creating an environment that encourages them to stay.

3. **Physician Re-entry Program** – Offers currently practicing family physicians the ability to re-enter into the training system to acquire advanced training in family medicine or to enter into a specialty training program. Annually, there are 20 third year family medicine re-entry positions and 20 specialty re-entry positions available. Physicians in this program are required to return service in an approved underserviced community once training is completed.

4. **Rural and Northern Medical Training Programs** – The Health Ministry funds a number of programs to train medical students and residents at teaching hospitals in northern and rural Ontario to give them the experience and skills they need to practice effectively in this environment after graduation. Examples of the programs are; South Eastern Rural Clerkship Program, Northwestern Ontario Family Medicine Program, Northeastern Ontario Electives Program, etc.

5. **Service Retention Initiative** – This program encourages the provision of services in areas of undersupply. As a condition of enrolment, physicians must agree to assist in recruiting additional physicians to their areas. Recruitment will allow the physician to adjust his/her practice by, for example, redistributing patient services to their colleagues to avoid or minimize the effects of future threshold reductions.

6. **Initiatives Under Development** – 1) Forty-eight rural hospitals will receive $15,000 per annum financial incentive for GP on-call funding. 2) All hospitals providing hospital on-call coverage funding except federally-funded hospitals or those operating with an alternate funding plan which covers on-call services. GPs and FPs will be funded if they ensure provision of after-hour hospital services such as surgical assisting, emergency department back-up coverage and in-patient care. The amount payable varies depending on the size of the hospital and the number of participating physicians. A similar program exists for specialists. 3) As part of the agreement between the Ontario Medical Association and the Ministry of Health, a rural and northern clinical clerkship program for 3rd and 4th year medical students is being developed. The funds cover administrative, travel and accommodation and preceptor costs for students studying at any of the five medical schools who undertake clerkships in rural and northern areas of the province, for a minimum of four weeks to a maximum of 12 weeks.

7. **Ontario’s Underserviced Area Program (UAP)** is one of a number of supports provided by the Ministry to help rural and northern communities recruit and retain health care professionals. Between April, 1995 and Sept 2001, communities designated as underserviced were successful in recruiting 302 General/Family Physicians and 193 Specialists.
Designation of communities as underserviced is an ongoing self-assessment process wherein communities identify themselves to the Ministry as being in need of recruitment and retention assistance, based on a standard set of criteria. Only northern communities may be designated as “underserviced” for specialists. There are a number of financial incentives under the UAP:

- $40,000 incentive grants paid over four years to GP/FPs and psychiatrists who relocate to designated northern communities.
- $15,000 incentive grants paid over four years to GP/FPs who relocate to designated southern communities.
- $20,000 inventive grants over four years to specialist who relocate to designated communities plus a $20,000 grant if the specialist provides a minimum of 12 days of outreach services per year.
- $15,000 incentive grants paid over three years to audiologists, chiropodists, occupational therapists, physiotherapists and speech-language pathologists who relocate to fill positions in these communities.

8. Through the Northern Physician Retention Initiative (NPRI), eligible physicians in northern Ontario will receive a $7,000 retention initiative paid at the end of each year in which they continue to practice full-time in northern Ontario. They also have access to $2,500 for each year of eligibility under a CME program for rural and isolated physicians.

Ontario has a number of other initiatives aimed at physician recruitment, practice support and enhancing access to medical services, such as free tuition for final year medical students, residents and physicians in exchange for a full-time three or four year return-of-service commitment in an eligible underserviced community, resident placement program, and a program to recruit 106 new Nurse Practitioners to address the health care needs of rural, northern and underserviced areas. More detailed information on all of these initiatives has been provided to David Kay, Program Manager, RPAP.

Newfoundland

Newfoundland's Resident and Medical Student Practice Incentive Program (referred to as the Family Practice Incentive) is focused on rural areas of need. This program offers a financial incentive to 4th year medical students and 1st and 2nd year medical residents pursuing training in Family Practice. Incentives are offered to those who agree to practice in an area of need within the province upon completion of training. Other programs (Medical Specialist Resident Bursary Program and the Psychiatric Resident Bursary Program) offer bursaries to those who agree to practice in an area of need within the province after completion of training.

The province offers retention bonuses payable to salaried physicians already practicing in rural areas. The bonuses replace a system of geographic supplements. The rate of the bonus depends on the location of the practice within the province. For General Practitioners (salaries between $100,000 and $120,000 annually), the retention bonus varies ranges from $2,500 to $10,000 after 12 months of eligible service to $7,500 to $30,000 after 36 months of eligible services. For specialists (salaries between $120,000 and $144,000), the retention bonus varies from $4,000 to $12,000 after 12 months of eligible service to $12,000 to $36,000 after 36 months of eligible services.
New Brunswick

New Brunswick offers location grants of up to $25,000 to newly recruited family physicians and up to $40,000 for specialists who agree to practice in hard to recruit to areas. In return, physicians are required to practice in the location for a period of five years.

The Supernumerary Residency Training Program provides financial support in the form of residency training for students who are unable to obtain a residency position, are unable to gain entry to their preferred specialty and for foreign medical graduates to obtain licensure. Sponsorship under this program requires a return for service agreement of a minimum of one year for each year of support for the first two years, and one-half year for each subsequent year of support.
APPENDIX 2 – SOME GOOD NEWS STORIES

As the consultants gathered information for this report, some Regional Health Authorities, communities or individual names came to our attention as having good practices in place to support successful physician recruitment or retention in the community. These “best practices” are provided here, as examples of some of the positive activities in this regard throughout the province. This list is not meant to be all-inclusive. There are certainly many other communities and Regional Health Authorities also involved in supportive and innovative activities. This list provides some examples of activities being undertaken in support of rural physicians and their families.

The “best practice” activities have been grouped into the three categories used by the RPAP in its document “Retention of Rural Physicians: An Action Plan for 2001-2002 and Beyond”: Community, Family/Lifestyle, and Professional.

Community

1. To assist in determining the need for additional physicians in a community, David Thompson Health Region utilizes a Needs/Impact Analysis that starts with an assessment of community services needs. This assists in determining the impact of adding another physician(s) into a community, and ensures that new appointments are made within the context of a Physician Manpower Plan. It also helps build consensus in the community that there is a need for another physician. The Needs/Impact Analysis:
   • Provides an assessment of community needs. The measures include maintenance of programs, overworked physicians, length of waiting period for elective cases, community demographics;
   • Predicts the impact on future physician hospital resource utilization;
   • Ensures that the new appointment takes place in the context of the Physician Manpower Plan;
   • Provides adequate pre-warning in order to accommodate the requirements of the new appointment;
   • Allows medical staff an understanding of the impact of the appointment on their practices; and
   • Provides the new or replacement physician with knowledge of available resources and his/her hospital work schedule on commencing practice.

The RHA finds this a useful exercise, but acknowledges that this tool has some drawbacks, particularly that it may not reflect community need if it is used to cap hospital medical staff and programs rather than as an exercise to accurately determine community needs and permit an understanding of the costs to be met, or trade-offs to be made in order to respond to community needs.

2. The town of Bashaw is a good example of a community recognizing the need to become involved in physician recruitment and retention due to experiencing a shortage of physicians in the community. The town’s Health and Wellness Foundation is taking an
active role in supporting the recruitment of physicians to the community. The community presently is without physicians, and is being served by physicians from a nearby community on a part-time basis. The community has worked with the David Thompson RHA to offer incentives to potential recruits. They will offer free office space for six months, new equipment, supplies and furniture for the office, and provide a receptionist at no cost to the physician(s). The group is also prepared to cover tuition costs and some housing costs if required to attract physicians to the community. This group acknowledges the need to ensure good support for the physician and for the whole family, once they have been successful in recruitment. The town manager noted that she felt it would have been very helpful for the town to have had a good website complete with pictures, expounding the positive attributes of the community, as a complement to a promotional package to send out to prospective recruits.

3. Fox Creek has a Medical Services Committee in place as an arm of the town council. The committee acts as a liaison or bridge between the hospital and the Aspen RHA and helps with morale and disciplinary issues. The group has no formal terms of reference, but has been instrumental in applying for incentive funds from companies and conducting other fund raising activities. The committee would have a role in the recruitment of another physician if it is determined that a second full time physician is required. At this time there is one physician supplemented by three physicians doing locums.

4. The Falher and Community Association for Professional Services raised funds for a new clinic in the community. The Town of Falher then loaned the Association the balance of the funds for the clinic with no interest charged.

5. The Fox Creek Medical Services Committee has been involved in putting together an incentive package for physician recruitment, including covering the annual costs for the clinic and medical receptionist and is currently looking at innovative ways to acquire a larger clinic. The group has also become involved in supporting the recruitment of a nurse and a mental health worker, and found a way to pay for the recertification for a laboratory technician. The committee is presently looking at ways that the town can better support physicians and families over the long term. Recently, the town held a Community Appreciation Night for the physicians working in the community.

6. Picture Butte has in place a Picture Butte Recruitment Committee, as an arm of the local Chamber of Commerce. This committee is comprised of ten members, including the two local physicians. The Chair of the committee indicates that the group tries to “cover all bases” in terms of welcoming and supporting the physicians. They have arranged for pre-visits to the community for prospective physicians, including picking the family up at the airport and staging a “grand tour” of the town and area. Once the family moves into the community the group determines how they can be supportive, and then maintains contact with the families. The committee worked to find clinic space and one local contractor came forward to build a clinic (at his own expense) with a three-year commitment from the physician that he would stay in the community. The committee has arranged to cover the cost of the receptionist for the clinic, as well as other expenses. The Chair of the committee offered to meet with other community groups who are thinking of setting up a similar committee to support physician recruitment and retention.

7. The Smoky Lake Regional Physician Recruitment and Retention Committee works with surrounding municipal authorities, all of which contributed to the purchase of a house in
Smoky Lake which is rented to physicians. The Town of Smoky Lake rented vehicles for the last two physicians recruited to the community.

8. The Town of McLennan owns the local clinic, and provided two years free rent to the physicians.

9. Vulcan’s medical clinic is in the hospital and the physicians each pay $500 monthly rent for clinic space. They also cover the cost of their own staff. The physicians feel this arrangement is a benefit to them, and reduces their overhead costs.

**Family/Lifestyle**

1. Health Authority #5 has a program in place ($5000 annually) to support spouses and families to attend out of town conferences with physicians.

2. Many of the communities within East Central RHA have physician recruitment committees in place, which, in conjunction with the RHA, will arrange visits to the community for prospective physician recruits and families, and ensure that the family has an opportunity to see all the amenities within the community and surrounding area.

3. The physician group in Hinton, and particularly, the spouse of one of the physicians, ensures that the family of any newly-recruited physician is taken under their wing and supported in any way that is required. Interestingly, there is now only one foreign-trained physician in Hinton (about 18 years tenure), while all the other physicians are Canadian or Alberta trained. This is thought to be attributable, at least in part, to the efforts of the community and local physicians, in concert with the RPAP, to bring students and residents to the community to look at the work, practice, and amenities within the community. The community affords physicians a wide scope of practice, including full emergency and surgery services, making it one of the easier communities to recruit to.

4. A physician from Vermilion comes to the Mannville clinic on a half-time basis. The Mannville village administrator plays an active role in supporting the physicians in both Mannville and Vermilion. He tends to get involved in a variety of matters, on an as-needed basis, for example:
   - Arranging for a local car dealership to meet with newly recruited foreign-trained physicians coming to the community, to ensure a good deal can be made so that the physicians (new to Canada and perhaps without established credit) are able to arrange for a vehicle.
   - Arranging for a local individual to accompany one of the spouses on her first ever grocery shopping expedition.
   - Arranging introductions to district agriculture managers and providing information on farming to interested physicians. One physician has brought land and taken a keen interest in farming.
   - Ensuring families are connected to interests such as 4-H.
   - Facilitating the reduction in clinic rent in Vermilion for the physician that spends half of his time at the Mannville clinic.
5. The town of Manning owns a home which it rents to physicians. This is helpful because housing can be difficult to find in a small community such as Manning. The same physician and family have been in the house for at least three years.

6. The Hardisty and District Recruitment Committee is an arm of the Hardisty Town Council, and also covers Amisk, Hughenden, and Lougheed. The town purchased a house for physicians to rent, with some of the funds coming from surrounding counties. The committee is sensitive to the culture and social shock experienced by physicians and families if they arrive from another country, and does their best to provide support to the families by connecting them with other families with similarly aged children and similar interests, and by staying in touch through the adjustment period.

7. Some of the five physicians in McLennan share on-call responsibilities on weekends so that one physician does not have to cover all of Friday, Saturday and Sunday. This seems to work well with this group, particularly so when there were only four physicians sharing the on-call work load.

8. The two physicians in Consort share on-call responsibilities with the physicians in Coronation and Castor. The physician on duty handles on-call duties for two hours at a time at each of the three hospitals. There is about a ½ hour drive between the centres. This arrangement permits a one-in-six weekend on-call roster for the physicians.

9. The Regional Health Authority purchased a house in Coronation for the use of the physician in return for a five year commitment of service in the community.

10. As Consort has the only facility in the area that still delivers babies, the community has raised funds for a fetal heart monitor and other equipment for the hospital.

**Professional**

1. Headwaters RHA provides physicians with a retention bonus after three years, in the form of $1000 per year to be used for CME activities.

2. David Thompson Health Region had a Physician Liaison Council under the auspices of the Medical Advisory Committee. The purpose of the Physician Liaison Committee is to ensure a stable, constructive, and long term relationship between the Health Region’s Authority and Physicians, by providing a forum for the discussion of broad Health Care issues, and other issues of mutual interest or of concern to either party.

3. Aspen Regional Health Authority recognizes the importance of maintaining a close partnership with communities to recruit and retain physicians, rather than taking this on strictly as a RHA responsibility. The Regional Medical Director and the Regional Services Officer (who is responsible for the administrative side), maintain a close relationship order to reduce issues around balancing the clinical role of the Medical Director with administrative functions.

4. Mistahia Regional Health Authority offers a $50,000 loan guarantee to newly-recruited physicians, along with the $10,000 relocation incentive and the $20,000 signing bonus. The region has found that Part 5 physicians, especially, can have difficulty obtaining credit, especially before work permit/immigration papers are in place.
5. Northwestern Regional Health Authority offers newly recruited physicians several incentives, including relocation expenses, rent free accommodation for six months and a car for three months, in addition to $10,000 per year for three years. The RHA actively supports CME (remote courses through teleconferencing, and subsidizes cost of medical books). The RHA is considering supplementing the rural on-call payments as well.

6. Palliser Regional Health Authority has a committee in place to consider recruitment incentives. The region currently offers moving expenses, signing/relocation bonus of $15,000 to $20,000, and a loan of $50,000, interest-free for one year.

7. Peace River RHA offers newly recruited physicians moving expenses, up to $10,000 for special skills, and $1000 per month for up to 20 months (includes the RPAP $10,000 grant if Alberta-trained physicians). To help retain physicians, the region offers assistance with CME (video-conferencing and ACLS training within region).

8. Northern Lights RHA has established a Physician Recruitment Committee, including the Regional Medical Director, the Vice President, Physician Liaison, two Board members, and a local businessman. The region offers newly recruited physicians $20,000 to help set up an office, $15,000 relocation expenses (repayable), and $10,000 signing bonus. Also provided is three months interim accommodation. The region ensures that there will be an orientation for the new physicians and families to Fort MacMurray, including schools and other amenities, and arranges a welcome luncheon with department heads, other local physicians, etc. To support physician retention, the RHA tries to ensure that physicians have an opportunity for input at all levels of decision making.

9. The Regional Medical Director for Health Authority #5 indicated that he feels it is important that the region take care not to recruit a physician that might be disruptive to the existing group of physicians. In that region, there is a basic core of physicians that treat each other well, and have a strong positive relationship to each other.

10. Keewatinok Lakes RHA provides a moving allowance as well as a $30,000 interest-free (three years) loan to newly recruited physicians. There is a housing subsidy in place for Demarais/Wabasca. The region has a region-wide tele-health network and supports CME via regular tele-health sessions.

11. East Central RHA will pay moving expenses up to $10,000 and legal expenses up to $1500 for newly recruited physicians. The RHA will also pay $1500 to help cover the cost of taking the Medical Council of Canada Evaluating Examination for foreign-trained physicians who are willing to relocate to the region.

12. Lakeland RHA has recently stepped in to support a clinic/physician in the village of Mannville. The physician is from Vermilion, but holds a clinic in Mannville on a ½ time basis. Previously, the village had owned the clinic and looked after electrical costs and taxes, leasing the clinic back to the physician for $1.00 per year. In March 2000, the RHA supported the move of the clinic into the former outpatient clinic in the Health Centre, and paid for some renovations. The new clinic is wheelchair accessible, and generally a better facility than the old clinic was. Existing Health Centre staff is being utilized, reducing the overhead costs. The village contributed the furniture from the former clinic. A group of individuals in the village raise funds to support the physician and clinic on an as-needed basis.