Alberta's Rural Physician Action Plan: an integrated approach to education, recruitment and retention

Education

Éducation

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Abstract

THIS PAPER DESCRIBES THE DEVELOPMENT and characteristics of a comprehensive, integrated and sustained program for the education, recruitment and retention of physicians for rural practice in Alberta — the Rural Physician Action Plan. The participation of key stakeholders (including government, the provincial medical association, the licensing authority, faculties of medicine, practising rural physicians and regional health authorities) and a sustained program budget have been key organizational issues for success. Critical to the effectiveness of this program has been the focus on professional and lifestyle issues targeting 3 distinct groups: physicians in training, physicians in practice, and rural communities and health authorities. Substantial program funding since 1991–92 of up to $3 million per year has increased rural-based activities significantly. For example, 87% of medical students and 91% of residents in family medicine in Alberta now experience 4 weeks or more of rural practice. The authors believe that the historic issues and recent trends militating against recruitment and retention of rural physicians will continue unchecked without comprehensive and sustained approaches such as Alberta's Rural Physician Action Plan.

Résumé

CE DOCUMENT DÉCRIT L'ÉLABORATION et les caractéristiques d'un programme complet, intégré et soutenu d'éducation, de recrutement et de rétention des médecins dans les régions rurales de l'Alberta — le plan d'action pour la médecine rurale. La participation d'intervenants clés (y compris le gouvernement, l'association médicale et l'ordre de la province, les facultés de médecine, les médecins ruraux actifs et les administrations régionales de la santé) et un budget soutenu pour le programme sont les éléments clés de la réussite. Il est crucial pour l'efficacité du programme de concentrer sur les enjeux liés à la profession et au style de vie les efforts qui visent trois groupes distincts : les médecins en formation, les médecins actifs, ainsi que les communautés rurales et leurs administrations de la santé. Grâce à un financement important accordé au programme depuis 1991–1992, soit jusqu'au 3 millions de dollars par année, les activités rurales ont augmenté considérablement. Par exemple, 87 % des étudiants en médecine et 91 % des résidents en médecine familiale de l'Alberta exercent maintenant 4 semaines ou plus en milieu rural. Nous sommes d'avis que les enjeux historiques et les tendances récentes qui jouent contre le recrutement et la rétention des médecins en milieu rural persisteront si l'on n'organise pas des interventions détaillées et soutenues comme le plan d'action pour la médecine rurale de l'Alberta.

Recruitment and retention of appropriately educated and trained physicians for rural and isolated communities is a concern not only in Alberta, but also across Canada and in most of the world. In the 1980s the availability of physicians for rural Canada became an increasingly prominent issue as federal and provincial governments grew more concerned with the increasing number of physicians in relation to the population and made proposals to reduce or elimi-

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nate the growth in overall supply of physicians. It was clear that the availability of physician services in rural Canada might decrease unless specific steps were taken to increase recruitment and retention.[1,2]

This paper describes the development and characteristics of a comprehensive and integrated program that was initiated in the province of Alberta in 1991–92 to recruit and retain physicians in rural areas.

Development of the Rural Physician Action Plan

In 1990 a multistakeholder working group was established in Alberta to develop a comprehensive and coordinated plan of action to recruit and retain rural physicians. The working group was assisted greatly by studies by the Alberta Medical Association[3] and the College of Physicians and Surgeons of Alberta[4] that identified the issues relevant to and the needs of physicians practising in rural areas of the province.

The report of the working group[5] was approved by the Cabinet of the Alberta government in December 1990. In April 1991 the government began funding the Rural Physician Action Plan (RPAP), and development and implementation of the initiatives started. From 1991–92 until 1996–97 the RPAP received directly $1.86 million per year, plus additional funding for special skills training and the Rural Locum Program, for a total of up to $3.11 million per year (Table 1).

Organization and focus of the RPAP

Alberta's RPAP has 3 key features. First, it is a cooperative and collaborative endeavour among key stakeholders involved in physician resource planning. Second, it is an integrated and comprehensive plan with initiatives that are aimed at several different groups and designed to support and build upon each other. Third, given that a student entering medical school cannot be prepared for rural practice in less than 6 or 7 years, it has a major commitment from Alberta Health for funding over an extended period.

Studies from many different jurisdictions show that 2 major categories of issues affect recruitment and retention of rural physicians: professional issues and lifestyle issues.[3,4,6] The RPAP is intended to address primarily professional issues, but it also encourages communities to enhance their capacity to address lifestyle issues.

The RPAP Coordinating Committee was established to oversee implementation of the plan by the key stakeholders. This provincial committee is accountable to Alberta Health (and thus the minister of health) for the programs and budget of the plan.

The RPAP addresses issues of recruiting and retaining rural physicians by focusing on 3 distinct groups: undergraduate medical students and postgraduate physicians (residents), physicians currently practising in rural Alberta, and rural communities and regional health authorities (RHAs).

Undergraduate and postgraduate medical education programs

The major objective of the programs for undergraduates and postgraduates is to encourage them to take up rural practice by providing positive experience in rural medicine and by fostering the development of the skills necessary for rural practice. The funding for these initiatives is shown in Table 1.

Table 1: Expenditures for the Rural Physician Action Plan, 1991–92 to 1996–97

	Year; funding					
	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97*
Undergraduate and postgraduate medical education programs						
Rural rotations	$408 668	$570 240	$929 880	$1 028 420	$1 100 575	$1 267 154
Special Skills Program†	365 320	365 320	328 778	621 044	584 512	600 000
Student Loan Remission Program	0	0	0	50 000	50 000	60 000
Subtotal	773 988	935 560	1 258 658	1 699 464	1 735 087	1 927 154
Programs for practising rural physicians						
CME initiatives	139 519	312 019	274 440	282 897	343 728	355 978
Enrichment Program	0	120 333	224 833	311 916	201 083	249 923
Rural Locum Program‡	377 450	293 650	293 650	293 650	293 650	578 650§
Subtotal	516 969	726 002	792 923	888 463	838 461	1 184 551
Total	$1 290 957	$1 661 562	$2 051 581	$2 587 927	$2 573 548	$3 111 705

*Budget estimates for 1996–97 are presented here, not actual expenditures.
†Funds derived from the postgraduate medical education budget.
‡Funds provided through the fee-for-service fund.
§Includes expansion to include the weekend locum program.

Rural rotation for medical students

Medical students are encouraged to select approved rural teaching sites for the mandatory 4-week rotation in family medicine during their clinical clerkship. The participation rate in rural rotations at the 2 medical schools has increased progressively from 57% for the classes of 1993 to about 87% for the classes of 1997.

Rural experience during postgraduate training

All residents in family medicine are strongly encouraged to spend a minimum of 4 weeks in a rural practice during their 2-year educational program. Both faculties of medicine encourage 20-week rotations. The participation rate in rural rotations among residents in family medicine in Alberta has increased from 74% in 1991–92 to 91% in 1996–97. The mean length of their experience in rural practice has also increased. A separate communication describes in detail rural education initiatives at the University of Alberta.[7]

Physicians in more than 50 rural Alberta communities have become a major influence in the education and training of medical students and residents in family medicine. Rural family physician preceptors are given a small stipend for teaching and supervision ($1000 per month for each student and $500 per month for each resident), and students and residents receive travel expenses and accommodation.

Faculty development for the rural physician preceptors is an essential element of these educational programs so as to standardize objectives and evaluation methods and enhance teaching skills. Faculty development activities include both large-group workshops and individual-based learning, derived from regular assessments of the learning needs of the physician preceptors. Each Alberta medical school has employed an additional physician, who devotes his major efforts to undergraduate and postgraduate education for rural practice.

Special skills training for rural practice

The Special Skills Program makes available a total of 24 funded residency positions for family medicine at the 2 universities for a third year of training in various special skills including anesthesia, surgery, obstetrics and gynecology, geriatrics and emergency medicine. These positions accommodate 33% of the residents completing training in family medicine in Alberta.

Student Loan Remission Program

From 1991–92 to 1993–94 the Student Loan Remission Program (SLRP) provided a remission of $10 000 at the end of 2 years of rural service in an approved underserviced community. In 1994–95 the program was revised to provide a maximum remission of $20 000; these return-of-service agreements can be signed at any point in residency training, with the first $10 000 payable immediately. From 1992–93 to 1996–97 a total of 17 physicians signed up for the SLRP. As a result of a recent review this program will probably be discontinued in 1997–98 because of low participation.

Programs for practising rural physicians

Several programs have been established to increase the recruitment and retention of physicians practising in rural communities by addressing professional issues. The funding for these initiatives is shown in Table 1.

Expanded continuing medical education programs

Funds are provided to enhance the regional conference programs and teleconference programs delivered to practising rural physicians by the 2 medical schools. Needs assessments are regularly conducted by the schools' continuing medical education (CME) offices to determine programming needs. In 1996–97 a total of 60 teleconferences were conducted by the 2 CME offices, and on average 79 rural physicians participated each week. A total of 48 regional conferences were held in rural communities during 1996–97. In addition, the Medical Information Service,[8] developed by the University of Calgary, provides a link from rural family doctors to library services and specialists in academic centres.

Enrichment Program

The Enrichment Program provides the opportunity for practising rural physicians to upgrade existing skills or gain new skills to meet the needs of their rural communities and regions. The skills must contribute to improved health services in the community or replace existing skills that will be lost because of retirement or other reasons. Physicians are funded for periods of 2 weeks to 1 year at a rate of $76 000 per year (prorated for the length of training). From 1991–92 to 1996–97, 13 physicians per year on average participated in this program; the mean length of training was 7.4 months.

Rural Locum Program

The Rural Locum Program provides locum coverage for physicians in communities with 4 or fewer physicians. Each community is eligible for 8 weeks of locum service within a year. During crisis situations the program has also

provided support to rural physicians. A weekend coverage program was recently initiated in an effort to ensure that physicians in participating communities will not be on call for more than 1 weekend in 4. Eligibility for this program is determined by the RHA and the local physicians.

Assistance for rural communities and RHAs

The purpose of the third component of the RPAP is to collaborate with rural communities and RHAs to enhance their abilities to identify and meet physician resource needs. Although many activities are specific to particular communities or regions, there are several overall initiatives.

"Pockets of Good News"

A study entitled "Pockets of Good News" was conducted in late 1993 to determine what was being done by rural communities in Alberta to recruit and retain physicians; the report of the study[9] included experiences with what works and what does not work and suggestions on how to increase recruiting success. This study established the basis for further planning by rural communities to address issues on recruiting and retaining physicians.

Physician recruitment fairs

The physician recruitment fairs, held annually in Edmonton and Calgary, began in the fall of 1994 and are funded by the RPAP. The fairs are designed to provide RHAs and communities with the opportunity to meet and begin recruiting medical students, residents and practising urban physicians. Each year 12 to 14 of the 15 rural RHAs participate in the fairs, which are considered an excellent venue for establishing contacts for recruitment.

Community profiles

Community profiles provide information on the RHAs and the communities within the regions that may be of value to a physician looking for a practice. In 1994 and 1995 the profiles were published in booklet format and distributed to all medical students, residents and interested physicians. The community profiles are now available electronically through the RPAP homepage (**www.family.med.ualberta.ca/rpap/**), so physicians around the world have access to the information.

Discussion

Improvement in the recruitment and retention of physicians requires a comprehensive, integrated and sustained approach. The RPAP, begun in 1991–92 in Alberta, represents such a set of initiatives. An international working group of family physicians has recently recommended a similar series of strategies.[10] Previous approaches to recruiting and retaining rural physicians in Canada have focused largely on financial incentives, including differential fee levels in Quebec and Manitoba and northern or isolation income programs in Ontario and British Columbia.[11] The initial impact of Alberta's RPAP is encouraging in terms of greatly increased experience of undergraduate medical students and postgraduate residents in family medicine in rural practice, increased CME and professional support through locums, and increased awareness and action by rural communities.

At the same time, however, several important counterbalancing changes have increased the difficulty in recruiting and retaining rural physicians. Among these trends are marked reductions in funding for the health care system in Alberta (about 20% in the 3 years 1993–94 to 1995–96); restructuring of the health care system and the creation of 17 RHAs, which take responsibility for all services (a change that has resulted in uncertainty regarding the facilities and services that will be available in rural communities); prolonged negotiations between Alberta Health and the Alberta Medical Association, which has created concern among physicians; and, most notably, the new and aggressive recruitment of primary care physicians to practice in the United States.

The outcomes of the RPAP have only recently undergone an initial independent assessment, and preliminary results indicate that increased recruitment and retention of rural physicians cannot be documented at this early stage.[12] The evaluators concluded, however, that if the RPAP had not been in place over the past 5 years, the number of rural physicians in Alberta would have declined rather than remaining stable. In the evaluation survey, 35% of the 285 responding physicians indicated that the RPAP had had a "critical" or "moderate" influence on their decision to move to or stay in rural Alberta.

The RPAP has recently been approved for continuation with additional resources. In times of significant restraints on funding in Alberta, the government and the other stakeholders clearly believe that these coordinated strategies to recruit and retain rural physicians must be aggressively pursued over a prolonged period.

Among the many contributors to the RPAP, we wish to acknowledge the contribution of Dr. Howard Platt, who was Provincial Medical Consultant for Alberta Health at the time this program was developed.

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This photo, sent to *CMAJ* by Dr. J.A. Webster of Yarmouth, NS, was taken by his father, Dr. Charles Webster, in 1897 while on a voyage from New York to Yokohama, Japan. Dr. Webster, who was later named a senior member of the CMA, wrote this note on the back of the photo: "Running the Eastings, South Indian Ocean, on ship *Iranian*. Heavy weather." Dr. Webster says his father was on the 4-masted, square-rigged ship because his uncle, Isaac Webster, was the ship's captain. Capt. Webster is standing to the left of the ship's wheel, with his back to the camera. Dr. Webster says some Canadians can still remember when a trip to Japan and other countries could take weeks or months, not the hours taken today. "People have it easy now," he says.