Community Engagement and Participation in Physician Recruitment

PHASE 1
FINDINGS REPORT

Version D1

Date 10-Apr-2019

Document History

Version	Date	Description of Changes
D1	10-Apr-2019	First circulated draft.

Table of Contents

List of Tables

List of Figures

List of Acronyms

DHW	Department of Health and Wellness
EU	European Union
MiW	Making it Work [45][46][48]
NSHA	Nova Scotia Health Authority

Introduction

In 2017, the Nova Scotia Health Authority (NSHA) developed a Provincial Recruitment Strategy [47] wherein community involvement with physician recruitment was recognized as key to the province's success. While there is a long history of community involvement in recruitment at local and regional levels, a provincial plan that collaboratively utilizes community and health authority resources has not been fully realized. As part of an initiative to change that, the purpose of this report is to capture the current state in Nova Scotia by drawing from recently obtained community feedback and an interjurisdictional literature review. This report will be used to inform a working group whose task it will be to define a provincial future state model for more effective physician recruitment in Nova Scotia.

Community feedback was sought for this work beginning June 2018. It spanned all management zones (Northern, Central, Eastern and Western Zones) and covered a diversity of geographical regions. Community representatives were invited to participate in focus groups about physician recruitment and to voice what does and does not work about the current state. They were also asked to share successful tactics and activities that might be applied elsewhere in the province. In parallel with focus groups, the NSHA conducted an interjurisdictional literature review of physician recruitment in Canada to help place Nova Scotia into a national context. The findings from both sources are presented herein, followed by a series of discussions that synthesize and interpret them.

Recruitment in Nova Scotia

As of 2016, physician recruitment in Nova Scotia is the responsibility of NSHA having been previously with the Nova Scotia Department of Health and Wellness (DHW). However, the NSHA recruitment team is not alone in the province as many communities have opted to create local recruitment committees to champion recruitment in their region. Physicians already working in Nova Scotia also participate in recruitment as they seek to maintain, improve and expand their practices and the services they provide.

The NSHA has built a provincial physician recruitment service that supports local recruitment activities. One physician recruitment consultant is dedicated to each management zone (Northern, Central, Eastern and Western Zones) and is the link into the larger NSHA when necessary. Physician recruitment consultants support all NSHA departments including the Department of Family Practice. The NSHA also implements an operational physician plan that tracks the number and distribution of physicians and guides an internal NSHA recruitment process. In that process, recruitment for specific physician positions is approved and then pursued by a joint DHW and NSHA committee. Funding in Nova Scotia is issued by the DHW in accordance with their Physician Resource Plan.

Numerous as these efforts are, there is a shortage of physicians in this province and the distribution of family practices is uneven. A provincial plan that collaboratively utilizes community and health authority resources has not been fully realized, and thus Nova Scotia as a whole is likely not recruiting physicians as effectively as it could be. This report is part of an initiative to change that. It captures the current state by drawing from recently obtained community feedback and an interjurisdictional literature review.

Interjurisdictional Literature Review

Approach

An interjurisdictional literature review of physician recruitment in Canada has been conducted to help place Nova Scotia into a national context. To conduct it, NSHA library services were utilized as well as publically available search engines. This section summarizes the key themes that emerged. Key themes are summarized rather than presenting a detailed reproduction of literature in order to enable a meaningful discussion when combined with the feedback obtained from communities. Readers may obtain more details by following the references provided throughout this document.

Findings

Key themes that emerged from literature included challenges and constraints that surround physician recruitment and retention as well as successful recruitment tools and activities. Assembling these key themes, it became practical to organize them into the categories of **professional**, **personal** and **community**, as demonstrated by an Alberta study [44] that proposed the model in Figure 1. The themes that emerged from literature are summarized in Table 1 through Table 4.

Table 1 is a summary of **professional** themes from literature.

Table 2 is a summary of **personal** themes from literature.

Table 3 is a summary of **community** themes from literature.

Table 4 is a summary of the factors affecting the loss of physicians (retention).

Additional resources not referenced in these tables are listed at the end of this document. They are provided for further reading.

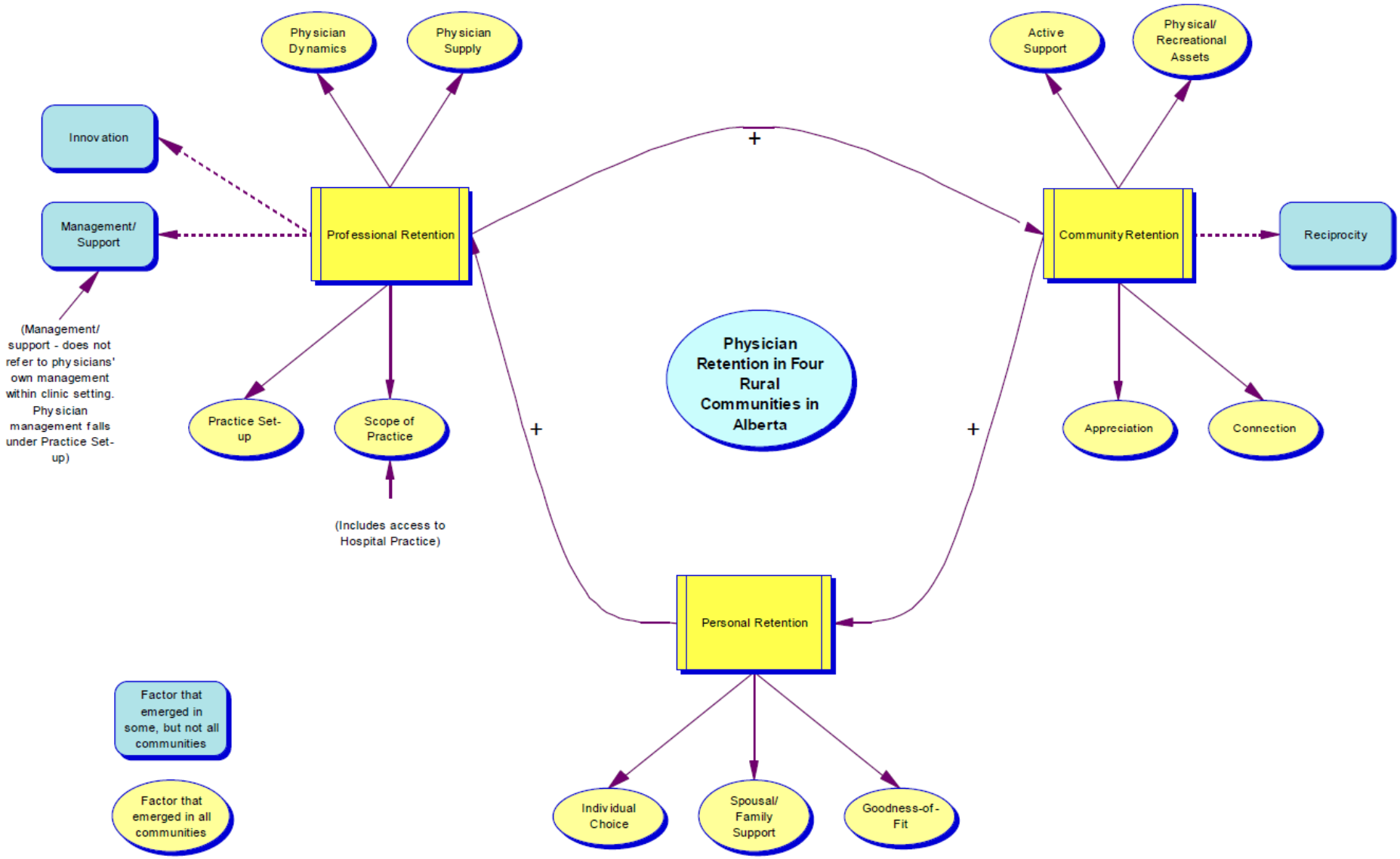


Figure 1: A proposed model from Alberta for the factors that affect rural physician recruitment and retention [44]

Table 1: Professional physician recruitment and retention themes in literature

Theme	Literature
1. Financial Incentives	a. Provide higher compensation to those willing to work in rural areas [4], [29] b. Provide financial incentives, such as short-term contracts [28], [29], [31], [32], [34]
2. Outreach	a. Send care packages or congratulation letters to medical students (could include informational pamphlets) [10] b. Red carpet recruiting events and suppers with participation from: Municipality and Foundation leaders, Businesses and Medical/Clinical representation including active physicians [10], [21] c. Provide informal career advice and role models [2] d. Rural secondary school outreach program run by medical students to improve interest in medical careers [3] e. Province hired physician recruitment coordinator (single phone number and site for physicians to access information) [23] f. Recruitment website with information about communities and ability to connect doctors with staff to help with navigation [39] g. Hire a relocation officer as a single point of contact to support and coordinate new recruits' relocation socially and professionally [45] h. Hire a recruitment officer to develop and implement strategy, coordinate activities, coordinate marketing, and network [45]
3. Healthcare Facilities	a. Modern collaborative healthcare facility [10] b. Provide quality care from a distance with video consultations using Telemedicine [11] c. Provide facilities with remote access to specialists [45] d. Provide high speed internet in rural areas [45]
4. Education and Professional Development	a. Expose medical students to Family Medicine earlier [27] b. Promote and support research in rural primary health care to garner interest and improve understanding of the unique challenges [45] c. Opportunity to conduct research [21] d. Opportunity to teach [21] e. Market rural positions to illustrate the variety of work (provide detailed workloads in order to show daily tasks) [14], [18], [30] f. Offer an exchange program for general practitioners in remote areas [45] g. Make training and academics available remotely from rural locations [45] h. Affordable, accessible and high quality professional development opportunities will improve services and retain staff [48] i. Strive to become the hub of a regional rural training program [48]

Theme	Literature
5. International Recruitment	a. Targeting physicians from the U.K. (short flights, no language barriers) [24] b. Difficult to transfer credentials and work in Canada (B.C. is a good role model) [20] c. Provide transition support to international medical students and doctors wanting to working in Canada (foreign-doctor program) [35], [36], [37], [38]
6. Locum Programs	a. Provide compensation for temporary positions [24], [31], [32], [33], [34]
7. Marketing and Candidate Identification	a. Transition away from selling the lifestyle and attractions and towards a message that "this is a healthcare organisation that we are proud of, with unique challenges and opportunities for development, and we need you" [45] b. Develop a profile of target recruits to match them with the right position and rural location [48]

Table 2: Personal physician recruitment and retention themes in literature

Theme	Literature
1. Spousal Job and Education Opportunities	a. Help with the job transition process of the physician's spouses as well as aiding in finding opportunities [1] [9] [21] [48]
2. Spousal and Family Support	a. Canadian spouses are more supportive of rural lifestyles when compared to spouses of international recruits [1] b. Tailor promotional/educational material for young families, highlighting opportunities for all members [45]
3. Matchmaking	a. If a physician is single, showcase other singles to pair them up with (Goderich) [21]
4. Positive Rural Experiences	a. Target those with rural backgrounds [10], [26] b. Provide short-term rural experiences [2]
5. Work-life Balance	a. Compensation incentives for less desirable work-life balance attributes [4], [29] b. Hire Nurse Practitioners to bare some of the workload [5], [25] c. Provide a balance that results in a higher quality of life [9] d. Manage on-call frequency [29]

Table 3: Community physician recruitment and retention themes in literature

Theme	Literature
1. Recreational Facilities	a. Community raised money to build a YMCA with a pool and skating rink, as well as renovated the library [21]
2. Support and Engagement	a. Higher quality of life for the whole family [9]

Theme	Literature
3. Local Recruitment Committees	a. Have committees specific to rural areas [30] b. Establish interdisciplinary rural recruitment and retentions groups [45] c. Collaborate with other rural services that may have similar recruitment struggles [45]
4. Programs	a. Implementation of distributed undergraduate medical education programs in rural and underserved communities [7]
5. Cultural	a. International medical grads working rurally are more likely to move provinces than Canadian grads [6]
6. Community Incentive	a. Housing availability is rated by physicians to be important [29] b. Moving assistance [32]
7. Community Involvement	a. Physicians and residents in the community should be involved in the recruiting process [30] [48]

Table 4: Themes in literature relating to the loss of physicians

Theme	Literature	Category
1. Lifestyle	a. Personal reasoning [30] b. Family reasoning [16]	Personal
2. Living Environment	a. Preference to living in a larger centre [15]	Community
3. Over-worked	a. Burnt out [15] b. Too many bureaucratic tasks [17] c. Spending too much time at the office [15], [17], [29] d. Too many daily patient appointments [17] e. Prevent physician burnout and job dissatisfaction by designing healthcare model and services to the population's needs [48]	Professional
4. Lack of Support	a. Do not feel supported professionally [16] b. Feel like a cog in the wheel [17] c. Support physician team cohesion to improve work environment and prevent isolation [48]	
5. Compensation	a. Not receiving sufficient income [17] b. In Nova Scotia, improved work conditions and quality of life will retain Canadian medical grads more than increased income will [6] c. International medical grads tend to move provinces seeking closer proximity to urban centres and higher income [6]	

Related Work from the European Union

Although this literature review is focussed on Canadian jurisdictions, important work out of the European Union (EU) is included [45][46][48]. It was discovered due to the participation of a Canadian community in northern Ontario and is for the same reason considered within scope. The EU work was a seven year international collaboration to identify and test solutions to the challenge of recruiting and retaining health professionals in rural areas. Partners were from Scotland, Sweden, Greenland, Iceland, Ireland, Norway, and Canada.

The first phase (2011 to 2014) identified, trialed and evaluated 29 diverse practices for improving recruitment and retention, and developed an early model for organizations to select and implement them [45][46]. In the second phase (2015 to 2018), the early model was integrated into the real recruitment programs of project partners, with each partner also implementing a tailored suite of practices. Partners published their final reports in January 2019.

In a single overarching document titled *Making it Work: A Framework for Remote Rural Workforce Stability* [48], published January 2019, the early model was refined into a mature and tested framework. The framework describes a spectrum of strategic elements that are fundamental to recruiting and retaining high quality health professionals in rural and remote locations. It is applicable to any community or organization. The authors concede that there is no single solution to the issue of rural recruitment and retention, and that multiple initiatives must be pursued to bring incremental improvement. The framework is merely a guide to accomplish that.

The Making it Work (MiW) framework consists of nine key strategic elements, grouped into three main tasks (plan, recruit, retain) with five conditions for success. It is illustrated in Figure 2 and is referred to throughout the discussions within this document as the "MiW rural recruitment framework", alongside other literature. The full MiW report is available online [48].

Figure 2: The MiW Framework [48]

Community Focus Groups

Communities were consulted for feedback beginning in June 2018. Consultations spanned all management zones (Northern, Central, Eastern and Western Zones) and covered a diversity of geographical regions. Community representatives were invited to participate in focus groups about physician recruitment and to voice what does and does not work about the current state. They were also asked to share successful tactics and activities that might be applied elsewhere in the province.

This section details the approach to community consultations, the means used for processing the feedback and, of course, the key findings.

Approach

Many communities across the province have been conducting physician recruitment activities since before the formation of NSHA. This has happened under various levels of organization ranging from just a few physicians working in their professional networks, to larger, more established committees with broad community representation. This has also happened at various levels of engagement with health authorities. Meanwhile, the NSHA (since its formation) has also been actively recruiting physicians. Therefore it is not from a lack of effort that this province, like most of Canada, has a physician shortage, and the distribution of physicians is uneven.

With so many active stakeholders and a long history, there is a diversity of experience, perspectives and knowledge in Nova Scotia. The intent now is to draw from that and catalogue what recruitment tools and practices have worked for communities in this province, what communities value in the work that NSHA is doing, and what changes could improve the effectiveness of our collaborative efforts.

To that end, a sample of eleven (11) communities were selected to consult with NSHA, representing all management zones and a diversity of geographical regions as shown in Figure 3. Each community's approach to physician recruitment is unique, and some had established local recruitment committees while others did not. In those that did, the committee was contacted directly for participation in focus groups. In those that did not, community leaders were contacted and asked to assemble the relevant local stakeholders, including: Health Foundations and Auxiliary leaders, First Nation's representatives, healthcare leaders, physician leaders, business and chamber of commerce leaders, school, social, and recreation leaders and other influential locals who could impact recruitment.

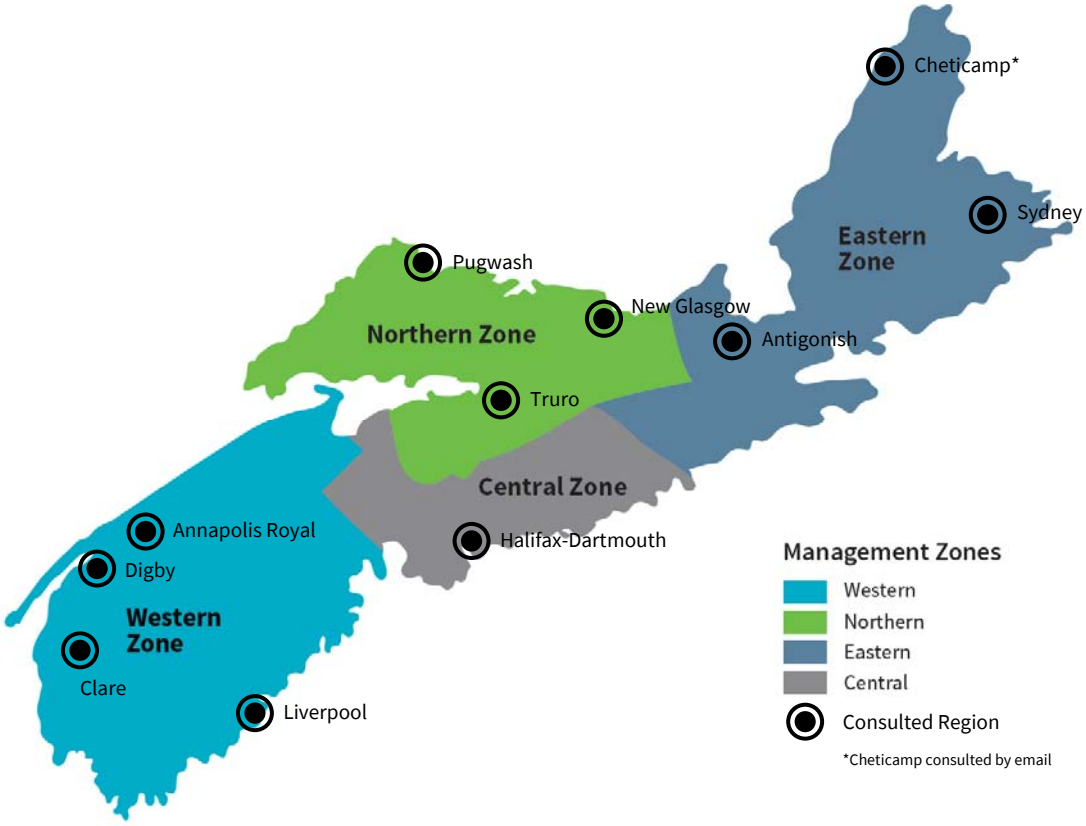


Figure 3: Community consultation sites

A focus group was held locally in each of the eleven (11) communities shown in Figure 3. Two NSHA public engagement facilitators attended each group to facilitate a discussion based on a series of questions prepared under six (6) headings. This was to guide participants through the workshop so that their feedback was accurately captured.

The following questions were presented to each focus group:

1. Activities that support recruitment
   - In what ways do individuals or groups in your community currently take part in recruiting doctors?
   - What expertise exists locally to support recruiting doctors?
   - What else do you need to more successfully promote your community potential doctor recruits?

2. Knowledge of community based physician recruitment efforts
   - What have you heard about or learned how other communities get involved in doctor recruitment?
   - How do you think those efforts/strategies might work in this community?

3. Community-led physician recruitment – interest and structure

- What added value do you think there may be in creating a local physician recruitment committee?
- What would your community need to make a local physician recruitment committee successful?
- What would you need/what would motivate you to become a member of a local recruitment committee in your area?
- If you don't feel a committee would be effective, what other means or structures might there be to contribute to physician recruitment?

4. Role clarity and existing structures
   - What do you understand to be the community's role in recruiting doctors, and what do you understand to be the role of NSHA/the health system?
   - What improvements to the current structure could be made to better position communities for success in recruiting new doctors?
   - What additional support do you need to be more successful?

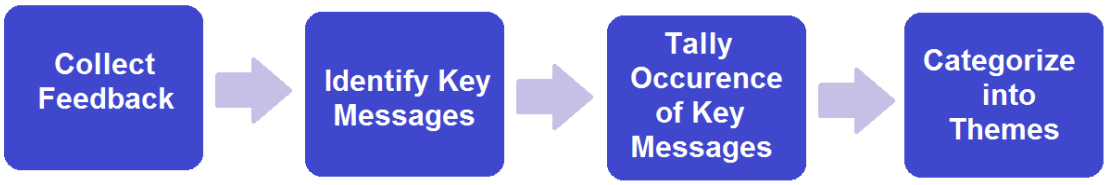
5. Improving community-based physician recruitment efforts
   - How do individuals or groups in your community currently take part in recruiting doctors?
   - What expertise have you developed locally to support recruiting doctors?
   - What actions or activities do you feel are working in your favour?
   - What are some of the things that you/we are not currently doing that we should be doing?

6. Activities that support retention
   - In what ways is this community successful in encouraging doctors to remain here?
   - If there are physicians who have left your community (excluding retirement, or relocation of a spouse, etc.) what were the factors in their decision?
   - What are some things we can change, improve, or start doing that will improve doctor retention?
   - What additional supports or resources do you need to help retain physicians?

Extensive feedback was provided by focus group participants and captured by the NSHA facilitators in detailed notes. The notes were digitized, circulated back to the originating communities for final input, and then forwarded to a core NSHA team who reviewed and processed them for presentation herein.

Processing

Community focus group feedback was processed by a qualitative method called content analysis so that it could be meaningfully presented and discussed herein. Content analysis is a technique for processing written or spoken communication, essentially counting the frequency of key messages. The process can be summarized as follows:



A total of 245 key messages were extracted and common ones were merged into themes. Themes were named to reflect the key messages merged to create them. The occurrence of each theme was then counted such that it represents the number of focus groups that each theme occurred in. It is important to note that the original feedback and the key messages composing each theme were all retained and remain available for reference.

Findings

The themes that emerged from focus groups are listed in Figure 4 along with their number of occurrences. Occurrences represent the number of focus groups that each theme occurred in, i.e. even if a theme was raised several times in a particular focus group, it was only counted as one occurrence. The complete data set down to key messages is available for reference in Appendix A:.

These focus group findings are discussed in the following section alongside those from literature for additional context.

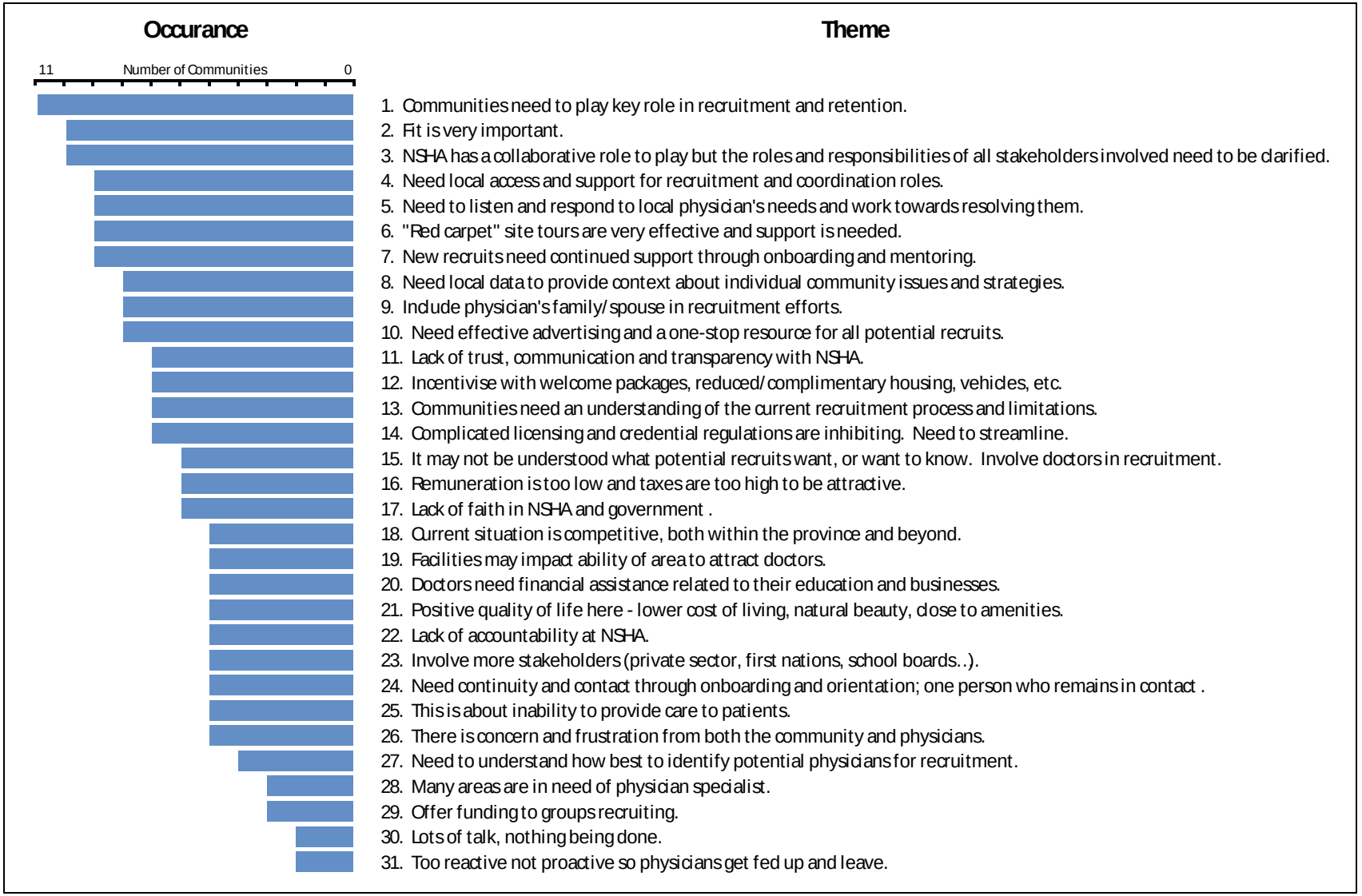


Figure 4: Community focus group findings

Discussion of Findings

A large amount of information was gleaned from the interjurisdictional literature review and community focus groups. In total, there are 63 literature review findings in Tables 1-4 and 31 focus group themes in Figure 4, composed of 245 key messages. This section is a series of discussions that synthesize and interpret the information from both sources. Each discussion begins with a table summary of the relevant findings.

As explained throughout this report, these findings and discussions will be used to inform a working group tasked with refining and defining a model for physician recruitment and retention in Nova Scotia.

Communities Need to Play a Key Role

Focus Group Theme(s)	Literature
Figure 4 Item 1 Figure 4 Item 3 Figure 4 Item 13	Table 3 Item 3(a) Table 3 Item 3(b) Table 3 Item 3(c) Table 3 Item 7(a)

The single most common theme that emerged from focus groups was that communities themselves need to play a key role in physician recruitment and retention. Participating community members noted that they have the knowledge of their region, the local network and the ability to act quickly.

This notion is also well represented in literature, where it is recognized that community recruitment committees for specific regions are important. Community engagement is a central element in the MiW rural recruitment framework [48] to ensure implemented solutions are feasible and actually work at the local level. The MiW framework also notes the importance of organized and sustainable relationships between communities and health providers. Successful committees are described in literature as not just being interdisciplinary but also collaborative, and not just collaborative with the relevant health provider(s) like NSHA but also with other rural services in the area, like the fire department, teachers, utility workers and the police force. Other rural services will face similar recruitment and retention challenges and, by working together, opportunities may be generated and barriers may be removed more effectively.

NSHA Needs to be More Collaborative and Clarify Roles and Responsibilities

Focus Group Theme(s)	Literature
Figure 4 Item 3 Figure 4 Item 13 Figure 4 Item 23	Table 3 Item 3(b) Table 3 Item 3(c) Table 3 Item 7(a)

Focus group participants recognized that NSHA has an important role to play, but that it needs to collaborate more broadly and more effectively by clearly delineating roles and responsibilities. Some roles and responsibilities were proposed by participants in focus groups, for example the identification of potential recruits, identification of mentors, licencing, and coordination. Local meetings were proposed with all the key players to discuss and clarify the overall approach. The key message was that roles and responsibilities are not currently well understood, and they need to be, by community recruitment committees and other stakeholders engaged in recruitment activities.

Literature supports this implicitly by documenting the importance of collaboration, where the need for effectiveness is implied. Also, the point is stressed in the MiW rural recruitment framework [48] in which information sharing is emphasized. Specifically, the framework stresses that a single, complete and coherent package should be presented to potential recruits including: position details, work environment, the benefits package, professional development opportunities, housing, commute times, personal and family recreation, elementary schools and career options for spouses.

Identification of Recruits

Focus Group Theme(s)	Literature
Figure 4 Item 2 Figure 4 Item 27	Table 1 Item 5(a) Table 1 Item 7(b) Table 2 Item 4(a) Table 4 Item 5(b) Table 4 Item 5(c)

There was a strong and consistent recognition at focus groups that “physician fit” is essential for their retention in a community. Various types of fit were discussed. Several communities think new graduates might not be a good fit for their region and that physicians in their mid- to late-careers might be better suited to function in the many capacities required in a rural setting. One community proposed that the personalities of new recruits could be better matched to the area and lifestyle. In essence, communities are asking whether incoming recruits should be referred to regions more selectively.

In alignment with this thinking, news articles and published papers point to higher retention rates in rural areas when recruits have rural backgrounds. There are also success stories of targeting physicians in the UK due to the common language and short flights to/from eastern Canada. The MiW rural recruitment framework advises to develop profiles of target recruits so that they can be matched to the right position and rural community [48]. Also discussed in

Marketing and Promotion on page 19, this practice encourages organizations to seriously consider the characteristics that a successful long term hire would have, and to hire appropriately.

Local Support Needed

Focus Group Theme(s)	Literature
Figure 4 Item 4	Table 1 Item 2(e) Table 1 Item 2(g) Table 1 Item 2(h)

Communities voiced that they need NSHA staff to be stationed or available locally in order to support local recruitment efforts, not "off in Halifax". The exact role of NSHA recruitment staff was also questioned amid confusion over what their responsibilities are. While some communities recognized the importance of NSHA representing Nova Scotia at recruitment events and generating interest in the province, many feel that more local support is needed. The more local support needed was described in two ways: (1) A dedicated "rock star" recruiter to the region; and (2) A coordinator of recruitment activities and ongoing recruit support. There was more mention of the latter than the former. In both cases the roles were perceived to be full time positions for each community.

Related literature describes similar services, although recruitment and coordination roles tend to be considered more regional than limited to one community. In the work that led to the MiW framework for rural recruitment [45], two roles were recommended: (1) A "relocation officer"; and (2) A "recruitment officer". In that recommended model, the relocation officer acts as a single point of contact for potential and new recruits before and during their relocation. For both professional or social needs, they direct new recruits to relevant information. Additionally, the role serves as a point of contact for employers (such as healthcare facilities) to advise on the induction process. The recruitment officer, on the other hand, develops and implements strategy, coordinates recruitment activities, coordinates marketing and builds relationships with other rural jurisdictions facing the same recruitment challenges. The services provided cumulatively by these two roles directly align with those requested by Nova Scotia communities.

Address Current Physicians' Needs

Focus Group Theme(s)	Literature
Figure 4 Item 5	Table 1 Item 3(c) Table 1 Item 4(b) Table 4 Item 3(b) Table 4 Item 4(b)

	Table 4 Item 4(c)

Supported by other community members, practicing physicians voiced some systemic concerns during focus groups. Non-clinical community members also had concerns about the issues facing physicians. They included overwork, poor moral, micromanagement by NSHA and the need to recognize seniority (i.e. more senior physicians need flexibility with their schedule, but are not currently given it). Moreover, there was consensus that NSHA needs to inquire about and resolve the issues that practicing physicians face (including but not limited to those listed above).

Much of the literature reviewed would be relevant in a discussion about the issues physicians face in Nova Scotia. The literature items listed above are only examples. The MiW rural recruitment framework has particular relevance [45][48]. Table 1 Item 4(b) is a recommendation to promote and support academic research on rural primary healthcare, which is also discussed in **Incentives** and Remuneration on page 21, **Involve Current Physicians** on page 22 and **Professional Development Opportunities** on page 25. Finding creative and effective ways of doing this would not only result in published papers to expand our understanding of the issues facing rural primary healthcare, but it might also raise the profile of rural practice and provide professional development opportunities (research) to rural doctors who would be best positioned to contribute to such studies.

Table 4 Item 4(c) is a recommendation to support physician team cohesion to ensure long term job satisfaction and retention. It is also raised in **NSHA Relationships** on page 20. Example means of doing that are given as: involve physicians in the decision of who to recruit, create social and group learning opportunities, include physicians in strategic planning, and create leadership opportunities.

Support for Site Visitations

Focus Group Theme(s)	Literature
Figure 4 Item 6 Figure 4 Item 29	Table 1 Item 2(b) Table 1 Item 2(h)

Many Nova Scotian communities have found site visitations (sometimes referred to as “red carpet events”) to be very effective recruitment tool and recommend it to others. Site visitations are essentially personalized tours for potential recruits with ‘all hands on deck’ to fully demonstrate the attractiveness of a community or region. Recruits may visit by themselves, with their family or as part of a larger group of recruits, depending on their wishes and arrangements with/by the community. The visitation can be hosted by a person or small team, often a local physician, mayor, chair of a recruitment committee, or other person(s) equipped and connected enough showcase the relevant facets of the

community, including introductions to local persons of interest. There were two pieces of feedback for NSHA: (1) Coordination support is needed, as physicians and other working people are often the ones organizing site visitations voluntarily on their own time; and (2) Flexible financial support is needed to cover hotels, meals, fuel for tours, small excursions, and so on. Flexibility is stressed on the topic of funding.

Literature recommends supporting communities by coordinating recruitment activities. In addition to the success of site visitations here in Nova Scotia, there are other success stories elsewhere in Canada too. At least one town (Goderich, Ontario) takes visitations a step further and organizes an annual weekend retreat for medical residents. The weekend includes a visit to the local clinic, an experience on the lake, as well as a gala evening in which the seating arrangement is carefully planned to build meaningful relationships.

Continuity of Support for New Recruits

Focus Group Theme(s)	Literature
Figure 4 Item 7 Figure 4 Item 24	Table 1 Item 2(c) Table 1 Item 4(f) Table 1 Item 5(c) Table 4 Item 4(a) Table 4 Item 4(b)

Community members point out that recruitment does not end when a contract is signed, and that retention is often the more difficult part. Onboarding and ongoing support of new recruits is required. One focus group suggested the role of "retention officer" as a point-person during the onboarding process and to continually check in with new recruits after they are settled. It was also suggested by some focus groups that physicians could mentor new recruits, but other groups said the opposite – that physicians were too busy to do so. In essence, the message from communities was that the onboarding process and ongoing supports for new recruits needs to be improved, because they are currently being left to fend for themselves.

The same sentiment is apparent in studies that have surveyed physicians, and bodies of knowledge recommend the same types of services to remedy this. Professional networks can be more limited in rural settings and it is easier to be/feel disconnected from the larger health authority and its resources. Literature highlights the importance of connecting rural physicians to mentors and other forms of informal career advice, as well as transition support for new recruits (especially international recruits). Taking it a step further, in 2013 Canada participated in a rural general practitioner exchange program with Ireland, Norway and Sweden to reduce professional isolation and expand networks (see Table 1 Item 4(f)). According to participant evaluations, it provided inspiration, perspective and new ideas for rural physicians to develop their practices at home. A similar program might be worth exploring inter-provincially within Canada, or provincially within Nova Scotia.

Utilize Local Community Data

Focus Group Theme(s)	Literature
Figure 4 Item 8	Table 3 Item 6(a) Table 4 Item 3(e)

Eight of eleven communities made reference to the idea that a recruitment strategy for their region should be highly tailored. To do that, they recognized the need for local data/information to provide context about local issues and opportunities. For example, in order to assemble an action plan and seek the right resources, demographics and surveys could be used to understand the needs of the community.

Evidenced-based and localized strategizing is supported implicitly throughout literature, but few articles discuss it explicitly. In the MiW rural recruitment framework [48], the very first elements of planning are to assess the population service needs and align the service model. The framework notes that if this is not done and monitored thereafter, workforce stability is threatened by burnout and job dissatisfaction – in addition to the population needs not being met. An example where local data could be used toward promotional material is given in Table 3 Item 6(a). Since housing availability is rated by physicians to be very important, it may be useful to obtain local real estate figures for use in promotional material.

Spouses and Family

Focus Group Theme(s)	Literature
Figure 4 Item 9	Table 2 Item 1(a) Table 2 Item 2(a) Table 2 Item 2(b) Table 2 Item 3(a) Table 3 Item 2(a) Table 4 Item 1(b)

A large number of focus groups identified that the whole family should be considered to recruit and retain physicians, not just the physicians themselves. Many have started (or want to start) young families and the decision to move will be made as a family unit, not as an individual. Important deciding factors cited in focus groups were quality education for children and good career opportunities for spouses. Community activities, associations and sports teams were also discussed.

Appealing to the interests of families is widely recognized as good practice in literature. Many jurisdictions tailor promotional material to families and some offer career counselling to spouses as well as support during their career transition. In one known case, a recruiter went so far as to introduce local singles to a physician temporarily placed in that community. One of the matches was successful, the couple was married, and the physician was thus

retained. On the retention side, physicians have reported that family quality of life is a significant reason for moving.

Marketing and Promotion

Focus Group Theme(s)	Literature
Figure 4 Item 10 Figure 4 Item 21	Table 1 Item 2(f) Table 1 Item 2(h) Table 1 Item 4(a) Table 1 Item 4(b) Table 1 Item 4(e) Table 1 Item 7(a) Table 1 Item 7(b) Table 2 Item 2(b) Table 3 Item 3(c) Table 3 Item 6(a) Table 1 Item 4(i)

There was lots of discussion about marketing and promotion in community focus groups. The general feedback to NSHA was that an effective advertising strategy is needed and that part of the strategy should be a central, one-stop resource for all potential recruits (a website). Other proposed approaches included social media, videos and ads in specialist publications. It was separately noted by participants (not necessarily tied to marketing and promotion) that Nova Scotia offers a positive quality of life including lower cost of living, natural beauty and proximity to amenities.

Literature supports the need for a recruitment website. It is suggested that websites should navigate potential recruits through every step of the process for recruitment and onboarding, and that promotional material should appeal to families as well as physicians themselves. In the work that led to the MiW framework for rural recruitment [45], it is suggested that health providers transition away from "selling the lifestyle" and move towards a new message that "this is a healthcare organisation we are proud of and we need staff who have the ability to meet the challenges of this unique environment." The same sentiment was shared by one focus group participant who said selling the lifestyle is not enough. Along the same lines, different sources (Table 1 Item 4(e)) suggest a marketing strategy that illustrates the variety of work involved in rural medicine by providing examples of daily schedules. At an early stage of recruitment, it is also advised to highlight the range of training, education and research opportunities open to candidates [48].

The MiW rural recruitment framework [48] cautions organizations to be cognizant of the characteristics sought in a new hire in relation to the promotion and advertising materials used to attract them. They may be targeting the wrong person. To that end, it advises the development of profiles for target recruits to help match them successfully (also discussed in **Identification of Recruits** on page 14).

Alternative means of marketing and promotion are also offered by literature. One of them seeks to make rural primary healthcare more desirable to physicians by raising its profile in scientific journals. Published research on the topic is currently under-represented relative to specialist topics (see Table 1 Item 4(b)), so it is proposed that health authorities promote research into rural primary healthcare and support physicians who wish to conduct it. Since published research would reach medical students as well as practicing physicians, this strategy would align with separate literature (Table 1 Item 4(a)) that highlights the importance of exposing physicians to family medicine early in their careers in order to recruit them later. Additionally, it would bring professional development opportunities to rural physicians because they would be ideally situated to conduct such research (also discussed in **Professional Development Opportunities**, page 25).

Another alternate means of showcasing a community is to aspire towards becoming a regional rural training hub (Table 1 Item 4(i)). As discussed in **Professional Development Opportunities** on page 25, this would create a consistent throughput of learners to see and learn about the region and perhaps choose to return for work.

Finally, Table 3 Item 3(c) advises to collaborate not just with other rural communities but also with other rural services who may share similar recruitment challenges. Doing so may create opportunities and remove barriers more effectively, including in marketing and promotions.

NSHA Relationships

Focus Group Theme(s)	Literature
Figure 4 Item 11 Figure 4 Item 17 Figure 4 Item 22 Figure 4 Item 26 Figure 4 Item 30 Figure 4 Item 31	Table 4 Item 4(a) Table 4 Item 4(b) Table 4 Item 4(c)

The relationship that NSHA[1] has with communities and physicians has been compromised. This was evident by the tone of some focus groups and was also provided as specific feedback. There was a lack of faith in NSHA to effectively recruit physicians, a perception of no accountability and a feeling that there is much talk but little action.

[1] Focus group participants often referred to "government", understood to mean both NSHA and DHW.

News articles from Nova Scotia and elsewhere also reflect this, with physicians reporting that they feel unsupported and like a cog in the wheel. The MiW rural recruitment framework [48] also includes team cohesion as an important element towards long term job satisfaction and retention, discussed further in **Address Current Physicians' Needs** on page 15.

Incentives and Remuneration

Focus Group Theme(s)	Literature
Figure 4 Item 12 Figure 4 Item 16 Figure 4 Item 20	Table 1 Item 1(a) Table 1 Item 1(b) Table 1 Item 4(b) Table 1 Item 4(f) Table 1 Item 6(a) Table 2 Item 5(a) Table 3 Item 6(b) Table 4 Item 5(a) Table 4 Item 5(b) Table 4 Item 5(c)

Various means of incentivizing physicians to work in rural regions were raised in focus groups. Higher overall rates, subsidized housing and vehicles, welcome packages and student loan support programs were all suggested as options.

Success in other rural Canadian jurisdictions as well as various published studies seem to point towards incentives and remuneration as an effective means of attracting physicians. However, it is worth noting that research [6] has concluded that increased compensation has only a modest impact on a physician's intent to move inter-provincially when they are trained in Canada. Work conditions and work-life balance have more of an impact. International physicians, on the other hand, have been shown to be more sensitive to compensation. This would seem to imply that physicians in the international job market tend to seek higher pay, whereas those who were trained in Canada, remain in Canada and want to stay in Canada tend so seek improved work conditions and work-life balance.

Two novel means of incentivising physicians to work in rural locations were found in literature. The first one is also discussed in

Marketing and Promotion (page 19) and **Professional Development Opportunities** (page 25). It aims to promote research into rural primary healthcare and support physicians who wish to conduct it [45]. Financial support in the form of reimbursed expenses and some type of remuneration could be offered selectively to physicians in priority recruitment locations, thereby acting as incentive to work there. The second novel means of incentive found in literature is to offer an exchange program, as discussed in **Professional Development Opportunities** on page 25and **Involve Current Physicians** on page 22. A program like this was offered in northern Ontario along with Ireland, Norway and Sweden [45]. Participants reported they found inspiration, perspective and new ideas for their rural practices back at home, and were exposed to a network of professionals they would otherwise not have been. In Nova Scotia, an exchange program like this would not necessarily need to be international to be successful, and could instead be limited to within Canada or even Nova Scotia itself. Regardless, a well-designed exchange program could be strong incentive to work in a rural location.

Licensing and Regulations

Focus Group Theme(s)	Literature
Figure 4 Item 14	Table 1 Item 5(b)

Licencing and credential regulations were described by focus groups as cumbersome, a barrier, a deterrent, too strict, arduous and heavy handed. Those that raised the issue said things have to change. The credential process needs to be easier, licencing needs to be streamlined and costs to physicians should be reduced or covered. A credentialing example was given of a physician who left the province on a study leave and had to be re-credentialed when they returned. Participants recognized that it's not just NSHA's responsibility to implement change in this regard, but also Dalhousie University and Canadian Residency.

News reports have also identified the transition process as being difficult in Nova Scotia and pointed to British Columbia as an example for how to improve (Table 1 Item 5(b)). British Columbia has a website that shows a flow chart with exact steps on how to move and work in the province. It gives candidates estimates on timelines and costs, and information about lifestyle differences in each community.

Involve Current Physicians

Focus Group Theme(s)	Literature
Figure 4 Item 15	Table 1 Item 4(b) Table 1 Item 4(f) Table 3 Item 3(b) Table 3 Item 7(a)

A large portion of focus groups (sometimes raised by participating physicians themselves) wanted physicians to be involved in the recruitment and retention processes. This was partially out of concern that the processes may otherwise be uninformed about the needs and wants of potential recruits. Physicians are also invaluable links to their colleagues through personal and professional networks and are natural points of contact for potential recruits.

The literature reviewed similarly calls for physician involvement in a number of ways. Interdisciplinary recruitment and retention groups are recommended, including physicians, of which there are already successful examples here in Nova Scotia and elsewhere across Canada. In the work that led to the MiW framework for rural recruitment [45], many good recruitment practices were presented that would have physician involvement. Specifically, one of them is to promote and support research by physicians in rural primary healthcare (also discussed in

Marketing and Promotion, page 19,

Incentives and Remuneration, page 21, and **Professional Development Opportunities**, page 25). In addition to the inherent benefits of research, this practice would raise the profile of rural healthcare by improving its presence in science journals and hopefully make it more desirable to physicians in the future.

Another suggested recruitment practice [45] is to offer an exchange program for rural practitioners in order to combat the professional isolation that can come with practicing in rural areas (also discussed in

Incentives and Remuneration, page 21, and **Professional Development Opportunities**, page 25). This type of program would introduce an entire network of physicians to recruits that they would otherwise not have access to.

A major element for retention in the MiW framework itself [48] is the training of future professionals, which could involve current physicians if they chose to teach. Table 1 Item 4(i) proposes that communities aspire to become regional hubs for rural training, as discussed further in **Professional Development Opportunities** on page 25.

Facilities Attract Physicians

Focus Group Theme(s)	Literature
Figure 4 Item 19	Table 1 Item 3(a) Table 1 Item 3(b) Table 1 Item 3(c) Table 1 Item 3(d) Table 1 Item 4(c) Table 1 Item 4(d) Table 1 Item 4(i) Table 2 Item 2(b) Table 3 Item 1(a) Table 4 Item 5(b)

Communities know that the facilities and the resources available in their regions impact a physician's decision to work there. Both clinical space and office space were discussed.

Literature confirms this and expands upon it. Modern collaborative healthcare facilities are very desirable for physicians to work in rural locations, for reasons of resources and work-life balance. Demonstrating this are success stories from Clare NS [10] and Goderich ON [21] where money was raised locally to build collaborative healthcare centres as part of a larger strategy to attract more doctors. The strategy as a whole worked. However, the strategy included more than just healthcare facilities and, indeed, other literature emphasises that many physicians are unlikely to move to rural locations unless the same or similar amenities are available as those in or near cities. Examples include recreational centres, sports teams, good libraries, high speed internet and opportunities for teaching and research. **Professional Development Opportunities** on page 25 discusses the attraction of training facilities if a community becomes a regional rural training hub. When families are involved, their needs add to the list of sought after amenities as discussed in **Spouses and Family** on page 18. Canadian research [6] has concluded that Canadian-educated physicians tend to move inter-provincially more for work conditions and quality of life than for compensation (though the same is not true for international physicians).

General Feedback from Community Focus Groups

Focus Group Theme(s)	Literature
Figure 4 Item 18 Figure 4 Item 25 Figure 4 Item 28	n/a

These themes from focus groups were raised by more than one group but do not overlap with a particular discussion herein.

Figure 4 Item 18: The current situation is competitive, both within the province and beyond.

Figure 4 Item 25: This is about inability to provide care to patients.

Figure 4 Item 28: Many areas are in need of physician specialists.

Work-life Balance

Focus Group Theme(s)	Literature
n/a	Table 2 Item 2(b) Table 2 Item 5a Table 2 Item 5b Table 2 Item 5c Table 2 Item 5d Table 3 Item 2(a) Table 3 Item 6(a) Table 4 Item 3(a) Table 4 Item 3(b) Table 4 Item 3(c) Table 4 Item 3(d) Table 4 Item 5(b)

Due to the prevalence of literature touching on the importance of work-life balance to physician recruitment and retention, this discussion is dedicated to it. Some of the literature listed has been referred to in other discussion points, but much of it has not.

The information gleaned from literature on work-life balance can be grouped into three categories: (1) Reports that work-life balance is important to physicians; (2) Alleviation and compensation; and (3) Quality of life for the whole family.

(1) Reports that work-life balance is important to physicians: It is clear in literature that physicians actively seek out work-life balance, and are not retained in areas where the balance is poor. They report moving because they're burnt out, have too many daily bureaucratic tasks, spend too much time working and have too many daily patient appointments.

(2) Alleviation and incentives: Canadian research [5] points to the Nurse Practitioner role as an opportunity to lighten the burden on physicians and decrease primary care wait times. It is noted that PEI is currently attempting to capitalize on this opportunity [25]. Other research [29] points to managing on-call frequency and hours worked to retain physicians in rural locations, and incentivizing to compensate where working conditions are less desirable. However, on the topic of incentives, further research [6] finds that improved work conditions and quality work-life balance are more effective at retaining physicians than increased compensation, at least for those educated within Canada. International physicians were shown to be more sensitive to compensation.

(3) Quality of life for the whole family: As discussed in **Spouses and Family** on page 18, physicians' families play a significant role in the decision of where to live. Likely for this reason, housing availability is reportedly an important consideration of physicians, and it is recommended that promotional material be tailored for young families to highlight the opportunities for all members.

Professional Development Opportunities

Focus Group Theme(s)	Literature
n/a	Table 1 Item 4(b) Table 1 Item 4(c) Table 1 Item 4(d) Table 1 Item 4(e) Table 1 Item 4(f) Table 1 Item 4(g) Table 1 Item 4(h) Table 1 Item 7(a) Table 4 Item 4(a) Table 4 Item 5(b)

Due to the prevalence of literature touching on the importance of professional development opportunities to physician recruitment and retention, this discussion is dedicated to it specifically.

Physicians want the ability to develop and participate in their profession, beyond their everyday practice, and it is important that they do so to maintain and improve healthcare services. Physicians want the opportunity to conduct research, to access training, to teach and to network. While these opportunities often exist in and near cities, they are difficult to access from rural locations. Unfortunately, Nova Scotia exit interviews reveal that one reason physicians leave this province is that they do not feel supported professionally. Research echoes this, reporting that work conditions and quality of life, more so than pay, are big motivators for leaving Nova Scotia, at least for physicians educated in Canada.

It is important to make rural-relevant training and academics available in remote locations that are affordable and high quality, and to highlight those options at an early stage of recruitment. A mixture of well designed "at a distance" or "technology enhanced" education programs together with "face to face" options should be offered [48], although the former two will likely require high speed internet not always available in rural locations (but is desirable in its own right as discussed in **Facilities Attract Physicians** on page 23).

Working in rural primary healthcare is a form of professional development in its own right, which should be emphasized in communications and promotional material [14] [18] [30] [45]. For example, rural practice involves a variety of work not usually found in cities. It is advised in literature to communicate that variety and combine it with a message that highly qualified professionals are

needed to meet the unique challenges of rural healthcare. This was also discussed in

Marketing and Promotion on page 19.

Several novel means were found in literature for bringing professional development opportunities to physicians practicing in rural locations. One of them is to promote and support academic research on rural primary healthcare [45], which is also discussed in **Address Current Physicians' Needs** on page 15,

Marketing and Promotion on page 19 and **Involve Current Physicians** on page 22. Rural doctors would be well positioned to contribute to such studies and enabling them to do so would have many benefits. The research itself would expand our understanding of the issues facing rural primary healthcare. Further, once published, the research could raise the profile of the topic and hopefully make it more desirable to physicians in the future.

Offering an exchange program for general practitioners in remote areas is another novel means of providing professional development opportunities. For example, a program was offered in northern Ontario [45] along with Ireland, Norway and Sweden (also discussed in **Involve Current Physicians**, page 22). According to participants of that program, the exchanges provided inspiration, perspective and new ideas for them to develop their rural practices back at home, as well as networking opportunities that would otherwise have been impossible. Exchanges like this in Nova Scotia would not necessarily need to be international to be successful. A similar program might be worth exploring inter-provincially within Canada, or, provincially within Nova Scotia itself.

Another means of providing professional development is captured in Table 1 Item 4(i) from the MiW rural recruitment framework [48]. Communities that can become regional hubs for rural training will benefit many times over. Firstly, they can offer their own physicians quality local training which is well documented to increase retention. Secondly, they can offer their own physicians local teaching opportunities. Thirdly, they create a consistent throughput of learners who gain awareness of the region and may choose to return to work. Lastly, being a training hub creates a professional community and prevents the isolation often associated with rural work.

Other Effective Recruitment Practices

Focus Group Theme(s)	Literature
n/a	Table 1 Item 2(a) Table 1 Item 2(d) Table 1 Item 4(a) Table 2 Item 4(b) Table 3 Item 4(a)

This section is meant to bring attention to effective recruitment practices in literature that are not emphasized elsewhere in this report. The relevant literature items are listed above. They include sending care packages to medical students, organizing outreach programs in rural high schools, providing physicians with short term rural experiences, and implementing distributed undergraduate medical education programs.

The Need for Recruitment Governance in Nova Scotia

Focus Group Theme(s)	Literature
n/a	n/a

It is clear that physician recruitment and retention in Nova Scotia is in need of processes and governance designed to address all of the discussions above. Communities themselves imply this with some of the most prominent themes from focus groups. They know they are best positioned to champion recruitment in their regions (**Communities Need to Play a Key Role**, page 13) and want to take the lead, but they want to do so within a defined framework (**NSHA Needs to be More Collaborative and Clarify Roles and Responsibilities**, page 13) and with support from government (

Local Support Needed, page 15, and **Support for Site Visitations**, page 16). Those sentiments and others are well supported by literature, as discussed throughout this report. In general, it appears that many communities are not clear what their roles are exactly, what resources are available, what recruitment rules and regulations exist, or who to consult when questions arise. In addition, the recruitment activities that communities conduct (or plan to conduct) require time and money and they are seeking financial support as well as NSHA resources.

Therefore, while there is broad agreement that collaboration is essential, there is little understanding of how best to do so. This points to either a lack of standardized processes or ineffective communication, or both. Clearly this must be resolved. The recruitment process in Nova Scotia must be captured, refined and made available to all stakeholders who must themselves be involved. Once the recruitment process is formally established it must then be governed to prevent creep in roles and responsibilities and to facilitate and circulate any changes.

The following section, **Next Steps**, outlines how recruitment processes and governance will be established in order to address the findings herein.

Next Steps

The next major step in this work is to assemble a working group, informed by this report. Drawing from the existing NSHA Physician Recruitment and Advisory Committee, the working group is planned to have representation from the following stakeholders (in no particular order):

1. NS communities (via the NS Federation of Municipalities)
2. Chamber of Commerce / Regional Enterprise Network
3. College of Physicians and Surgeons
4. Dalhousie University
5. Department of Family Practice
6. Doctors NS
7. Health Foundation(s)
8. MARDOCS
9. NS College of Family Physicians
10. NS Department of Health Wellness
11. NS Office of Immigration
12. NSHA Primary Health Care
13. NSHA Recruitment

Based on input from these stakeholders and informed by the findings herein, and as illustrated in Figure 5, the working group will capture and refine processes for recruitment and retention in Nova Scotia as well as decide on a practical governance model to maintain them. This will include clearly defined roles and responsibilities. NSHA will then prepare a package called a *Toolkit of Best Practices* for circulation to communities. It will contain a summary of the refined overarching process, the governance model and a series of guides for communities to use at their discretion.

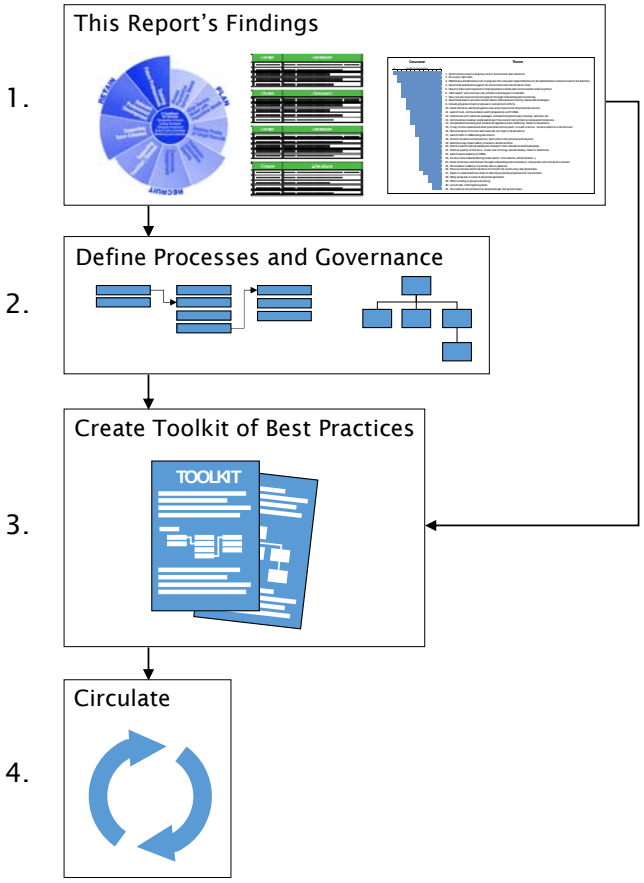


Figure 5: Next steps

Conclusion

This report captures the findings from 11 community focus groups on physician recruitment and retention in Nova Scotia, as well as findings from an interjurisdictional literature review. These findings are synthesized and interpreted into meaningful discussions that, cumulatively, will inform the next phase of work. In the next phase of work, a working group will define provincial processes and a practical governance model for physician recruitment and retention in Nova Scotia, and NSHA will circulate a package to communities.

References

[1] https://www.ncbi.nlm.nih.gov/pubmed/?term=Recruitment+and+retention+of+physicians+in+rural+Alberta%3A+the+spousal+perspective

[2] https://www.ncbi.nlm.nih.gov/pubmed/29452409

[3] https://www.ncbi.nlm.nih.gov/pubmed/28441129

[4] https://www.ncbi.nlm.nih.gov/pubmed/28441127

[5] https://www.ncbi.nlm.nih.gov/pubmed/25495058

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4729283/

[7] https://www.ncbi.nlm.nih.gov/pubmed/19422493

[8] https://www.definitions.net/definition/Corporate%20Governance

[9] http://www.cbc.ca/news/canada/nova-scotia/doctor-recruitment-nova-scotia-immigration-1.4525019

[10] http://www.cbc.ca/news/canada/nova-scotia/the-search-doctors-recruitment-healthcare-rural-medicine-1.4526131

[11] https://search.proquest.com/docview/210716128/77CFE7D716BA486CPQ/2?accountid=26764

[12] http://oss-watch.ac.uk/resources/governancemodels

[13] http://www.governancepro.com/news/

[14] https://srpc.ca/resources/Documents/CJRM/vol23n2/pg45.pdf

[15] http://www.cbc.ca/news/canada/nova-scotia/regular-check-ins-key-to-retaining-physicians-says-doctors-nova-scotia-1.4232444

[16] http://www.cbc.ca/news/canada/nova-scotia/few-doctor-exit-interviews-completed-health-authority-1.4229462

[17] https://www.careatc.com/ehs/5-reasons-why-physicians-are-leaving-the-practice-and-where-they-want-to-go

[18] https://www.ncbi.nlm.nih.gov/pubmed/29547381

[19] http://www.cbc.ca/news/canada/nova-scotia/doctors-nova-scotia-shortage-retirement-recruit-emergency-rooms-1.4087348

[20] http://www.cbc.ca/news/canada/nova-scotia/nova-scotia-doctor-recruitment-british-columbia-1.4535748

[21] http://www.cbc.ca/news/canada/nova-scotia/physician-recruitment-goderich-ontario-success-1.4538925

[22] https://www.cbc.ca/news/canada/nova-scotia/health-authority-doctor-recruitment-hires-1.4632894

[23] http://www.cbc.ca/news/canada/new-brunswick/doctor-recruitment-haddad-boudreau-1.3231843

[24] https://www.princeedwardisland.ca/en/topic/locum-opportunities

[25] https://www.cbc.ca/news/canada/prince-edward-island/health-pei-nurse-practitioners-new-hires-1.4564439

[26] https://www.ncbi.nlm.nih.gov/pubmed/29548259

[27] http://www.cmaj.ca/content/cmaj/180/1/25.full.pdf

[28] http://www.health.alberta.ca/initiatives/physician-resource-planning.html

[29] https://www.ncbi.nlm.nih.gov/pubmed/?term=Physician+recruitment+and+retention+in+Manitoba%3A+results+from+a+survey+of+physicians%27+preferences+for+rural+jobs

[30] https://www.albertahealthservices.ca/news/features/2015/Page11435.aspx

[31] https://www.yukon-news.com/life/the-great-doctor-hunt/

[32] http://www.practicenorth.ca/index.php?page=contracts-and-compensation

[33] https://www.cbc.ca/news/canada/north/european-union-northern-doctors-recruitment-1.3658345

[34] https://www.cbc.ca/news/canada/north/nunavut-spends-millions-on-temporary-doctors-1.1353803

[35] https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2017/international-medical-graduates-face-daunting-challenges-getting-help-is-key-to-success

[36] https://www.cbc.ca/news/canada/nova-scotia/nova-scotia-moves-to-resurrect-foreign-doctor-program-in-face-of-physician-shortages-1.4528258

[37] https://www.cbc.ca/news/canada/nova-scotia/loss-of-foreign-doctor-program-cut-more-than-40-physicians-from-n-s-workforce-1.4384664

[38] https://www.thestar.com/news/ontario/2014/09/01/foreign_medical_grad_finds_ontario_system_tough_to_crack.html

[39] http://www.cbc.ca/news/canada/nova-scotia/what-nova-scotia-doctor-recruiters-can-learn-from-b-c-as-they-target-the-u-k-1.4535748

[40] http://www.cbc.ca/news/canada/nova-scotia/nova-scotia-announces-new-immigration-stream-for-doctors-1.4547083

[41] https://www.saskatchewan.ca/government/news-and-media/2018/may/01/more-physicians-working

[42] https://globalnews.ca/news/3896216/saskatchewan-health-authority-launches/

[43] https://news.gov.mb.ca/news/print,index.html?item=41692

[44] University of Calgary, Physician Retention in Four Rural Communities in Alberta: A Collective Case Study (p.328) by Pamela Joann Cameron

[45] Northern Periphery Programme, “Recruit and Retain Solutions”,

[46] Northern Periphery Programme, “Recruit and Retain Business Model”,

[47] NSHA Physician Recruitment Strategy: http://www.nshealth.ca/sites/nshealth.ca/files/recruitment_strategy_2017-18.pdf

[48] Northern Periphery Programme, “Making it Work: A Framework for Remote Rural Workforce Stability”, January 2019. Available online at: http://rrmakingitwork.eu/wp-content/uploads/2019/03/Making-it-Work-Framework-for-Remote-Rural-Workforce-Stability.pdf

Additional Resources

1) Alberta Community Recruitment & Retention (2010): http://www.nadc.gov.ab.ca/Docs/RPAP-Workshop-10.pdf

2) Alberta Health Services – Physician Workforce Plan & Forecast (2017-2018): https://www.albertahealthservices.ca/assets/info/hp/phys/if-hp-phys-2017-workforce-plan.pdf

3) Canadian Association of Staff Physician Recruiters (CASPR): https://caspr.ca/

4) Canadian Journal of Rural Medicine

5) Health Match BC: https://www.healthmatchbc.org/

6) Manitoba Healthcare Recruitment Site: http://www.mhpnetwork.ca

7) New Brunswick Healthcare Recruitment Site: http://nbhealthjobs.ca/

8) Nova Scotia Physician Resource Plan (2012): http://www.doctorsns.com/site/media/DoctorsNS/PhysicianResourcePlanning-finalreport.pdf

9) PEI Physician Recruitment/Retention & Medical Education Strategy (2006): http://www.gov.pe.ca/photos/original/Health_Phy_RR06.pdf

10) Physicians in Canada – CIHI (2016): https://secure.cihi.ca/free_products/Physicians_in_Canada_2016.pdf

11) Physician Recruitment Agency of Saskatchewan – Annual Report (2016-2017): https://www.saskdocs.ca/web_files/prasrpt

12) Practice in BC – Physician Recruitment Site: http://www.practiceinbc.ca/

13) Saskatchewan Inter-Provincial Review of Recruitment Incentives – Appendix B (2011): https://www.saskdocs.ca/web_files/discussion-paper---recruitment-incentives.pdf

14) Saskatchewan Physician Recruitment and Retention Handbook (2017): https://www.saskdocs.ca/web_files/Recruitment%20and%20Retention%20Handbook%20August%202017_Final.pdf

15) Shaping our Physician Workforce: https://novascotia.ca/dhw/publications/Physician_Resource_Plan_Shaping_our_physician_Workforce.pdf

16) Social Sector Metrics Inc. and Health Intelligence Inc. – Environmental Scan Report (2011): https://novascotia.ca/dhw/publications/Physician_Resource_Plan_Environmental_Scan_Report.pdf

17) Recruitment Essentials – Health Force Ontario: http://www.healthforceontario.ca/en/Home/All_Programs/Physician_Recruitment_for_Communities/Recruitment_Essentials

18) Yukon Health and Social Services: http://www.hss.gov.yk.ca/healthservices.php

19) Yukon MD – Physician Recruitment Site: http://www.yukonmd.ca/

APPENDIX B

Governance Structures in Canadian Jurisdictions

Below are some notes on the governance structures applied to physician recruitment and retention in other Canadian jurisdictions. They were assembled ad hoc and are not considered complete. They are included here for reference only.

New Brunswick: New Brunswick has appointed a Physician Recruitment Coordinator, a province wide position resulting from a new strategy in 2015. This strategy involves having a single phone number and site for physicians to access in order to inquire about positions within the province. [23].

Prince Edward Island: The provincial government ensures an adequate supply of physicians through the implementation of the *PEI Enhanced Physician Recruitment/Retention and Medical Education Strategy*. (Additional Resources [9]).

Newfoundland: Had some success retaining medical graduates from Memorial University. These graduates have proven to be more likely to establish practice in Newfoundland or other rural areas. [26].

Quebec: More research required.

Ontario: Detailed recruitment essentials guide created for professional recruiters by Health Force Ontario. (Additional Resources [17]).

Manitoba: Recruitment is conducted through the MB Healthcare Providers Network. (Additional Resources [6]). In 2017, Manitoba announced that they are working towards amalgamating their eight existing health organizations into a single health authority, *Shared Health Services Manitoba*. [43].

Saskatchewan: Recruitment is conducted through the Physician Recruitment Agency of Saskatchewan. Almost 900 more physicians started working in Saskatchewan since 2007. [41]. In 2017, Saskatchewan dissolved their twelve health regions to form a single health authority, *Saskatchewan Health Authority.* [42].

Alberta: Alberta has developed an amending agreement between Alberta Health and the Alberta Medical Association. The amendment is focused on a commitment to establish a physician resource planning committee, which took need into consideration. In recent years Alberta has accumulated the highest number of physicians nationwide, although they still experience shortages in rural areas. [28].

British Columbia: British Columbia developed a free health-care recruiting service outside of the health authority, called Health Match BC (Additional Resources [5]). The province has also offered bonuses up to the amount of

$100,000 for doctors who could commit to practicing for three years in certain rural communities. [31].

Yukon: The Yukon launched a recruitment site in 2013 which is managed by the Yukon government. In 2013, the province also got its first dedicated recruitment resources, including a physician recruitment and retention officer, to support the new strategy. The Yukon also offers financial incentives, such as offerings up to $36,000 after practicing in the area for three years. The Northern Province relies heavily on locum programs, with incentives administered by the Yukon Medical Association. In order for a current state analysis to be complete, they created a doctorless-patient online registry where Yukoners can sign up to announce they are without a family physician. [31].

Northwest Territories: On top of locum programs, the Northwest Territories offers full-time physicians and specialists the following benefits: competitive recruitment and retention bonuses, northern allowance, call-back compensation, moving assistance, special leave, self-funded leave plan, sick leave, maternity leave and group health benefits. [32].

Nunavut: Nunavut has the fewest doctors per capita in Canada. They rely heavily on locum programs, spending $11.5M over 20 months in short-term contracts at Iqaluit hospital. They also look to community health centres run by nurses to accommodate their patrons. Nunavut is involved with a European Union project, *Recruit and Retain Project*, which had already identified 29 ideas for tackling the issue of attracting and retaining doctors in rural communities by 2016. Canada is the only country outside of the European Union to take part in the project. [33].