

# Transition Experiences for Physicians New to Rural Practice in BC

## Final Research Report



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THE UNIVERSITY OF BRITISH COLUMBIA

**Continuing Professional Development**

Faculty of Medicine

# Acknowledgements

This research primarily took place on the unceded, traditional, and ancestral lands of the Coast Salish peoples, including: x̣ẉməθḳẉəỵəm, Sḳẉx̣ẉú7mesh, Stó:lō, and Səḷíḷẉətaʔ/Selilwitulh, Nations. We are humbled and grateful to work, research, learn, and form connections on these lands.

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The New to Rural Practice Research team from the Continuing Professional Development department at the University of British Columbia (UBC)'s Faculty of Medicine included:

<b>Dr. Brenna Lynn</b>	Associate Dean, Principal Investigator
<b>Ms. Kathryn Young</b>	Senior Program Manager
<b>Ms. Deborah Watt</b>	Project Manager
<b>Ms. Gurveen Grewal</b>	Program Manager
<b>Ms. Stephanie Gariscak</b>	Research Assistant
<b>Dr. Ray Markham</b>	Physician Consultant
<b>Dr. Dietrich Furstenburg</b>	Physician Consultant

External research consultation and support, including data analysis and report writing was provided by AND implementation. The external team included:

<b>Dr. Maya Lefkowich</b>	Research Consultant
<b>Mx. Julia Santana Parrilla</b>	Research Consultant
<b>Ms. Jennica Nichols</b>	Research & Evaluation Consultant

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Questions about this report can be directed to Kathryn Young [kathryn.y@ubc.ca](mailto:kathryn.y@ubc.ca)

**Rural Coordination  
Centre of BC**



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## Acronyms

Acronym	Meaning
2SLGBTQI+	Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, plus individuals
BC	British Columbia
BC-PIP	British Columbia Physician Integration Program, a UBC CPD program that supports the transition and integration of IMGs from the provisional registry to full licensure to practice medicine in BC.
CHARLiE	Child Health Advice in Real-Time Electronically, a real-time virtual support pathway for health care practitioners in rural and remote BC communities to access pediatric support, including intensive, emergency, urgency care and collaborative or ongoing support.
CMG	Canadian Medical Graduate
CPD	Continuing Professional Development
IMG	International Medical Graduate
MaBAL	Maternity and Babies Advice Line
NTP	New to practice (i.e., early-career physicians)
NTRP	New to rural practice (i.e., physicians early in their rural medicine careers)
OBGYN	A physician who specializes in both obstetrics and gynecology
PRA-BC	Practice Ready Assessment - British Columbia, an assessment program for internationally educated family physicians who have completed residencies in Family Medicine outside of Canada.
RCCBC	Rural Coordination Centre of British Columbia
RCPD-MAC	Rural Continuing Professional Development Program - Medical Advisory Committee
ROSe	Rural Outreach Support, a real-time virtual support pathway for health care practitioners to access intensivist and critical care specialists.
RUDi	Rural Urgent Physician in-aid, a real time virtual support pathway for health care practitioners in rural and remote BC communities.
UBC	University of British Columbia

# Executive Summary

## Overview

Physicians who practice in rural communities in BC enjoy unique career advantages, such as: diversity of practice, high-level of independence, broad scope of clinical exposure, positive relationships with patients, financial incentives, and opportunities to be part of highly collaborative care teams. Yet, many physicians choose not to stay in the same rural community long-term.

The *Transition Experiences for Physicians New to Rural Practice in BC* study aimed to understand how to improve the transition and retention experiences for rural physicians. Physicians (n=22) between 6 months and 2 years into rural placements took part in 1-hour qualitative interviews. Qualitative interview data were analyzed by independent researchers using a deductive thematic analysis and synthesized to inform recommendations to facilitate future recruitment, retention, and ongoing supports. The UBC CPD team then solicited feedback from across its research team members and made iterative changes to the data analysis, discussion/conclusions, and recommendations sections in the report to incorporate the feedback.



## Findings



Physicians in this study were more likely to indicate a desire to engage in rural medicine and stay in the same community long-term if they had strong personal and professional relationships, or if they previously completed a locum in the same place. Physicians who grew up in rural communities indicated a preference to be a rural physician for the duration of their careers, and were the only physicians in this study to explicitly state their intention to stay in their current community.

Participants indicated that strategic career planning for rural practice was an important aspect of their: (1) ability to overcome the initial learning curve in their role, (2) overall career satisfaction, and (3) decision to stay in the same community. Locuming in rural communities, finding mentorship from more established rural physicians, seeking out additional training to suit community needs, and investing time into building relationships within rural communities were some of the strategies that participants employed. For international medical graduates (IMGs), participating in the Practice Ready Assessment – British Columbia (PRA-BC) program was helpful in their career planning as the provision of tools, resources, and background information allowed them to feel prepared to address community contexts and needs.

Some emerging findings of this study, which was conducted around one year into the COVID-19 pandemic, are: (1) participants experienced screen fatigue and expressed an interest in alternative modalities for education such as in-person in rural communities, asynchronous learning, and in-depth explorations of community-specific health topics, (2) the pandemic hindered participants' ability to build

new relationships with colleagues, (3) many chose to stay in the same community for the duration of the pandemic resulting in a heightened sense of permanence, and (4) participants felt their relationships with clinical teams solidified and they felt integral to the clinic team after having experienced the challenges in healthcare during the pandemic.

Despite unanimously agreeing on the benefits of rural practice, few participants confirmed long-term plans to stay. Some physicians identified that the inevitability of burnout, geographical isolation, and/or conflicting family needs would likely cause them to leave their community or pursue work in more urban areas. Thus, these contextual factors may significantly influence decision-making. However, educational initiatives that support all aspects of rural physicians' transitions to, and quality of life in, rural communities may improve recruitment and retention rates.

"I would never abandon a community in the middle of a crisis, but as soon as it's appropriate for me to leave, I would leave...and I think that attitude would be potentially echoed by other people in my age group who have watched older physicians sort of lose their lives to this."

## Recommendations/Conclusions

This study suggests that improving overall recruitment, retention, and job satisfaction for rural physicians must be prioritized alongside professional development and rural support organizations. Data indicate that some existing initiatives are working well. Specifically, findings support continued efforts to:

- Train physicians for rural medicine on an ongoing basis by strengthening physicians' confidence, self-reliance, and familiarity with unique populations' needs.
- Promote participation in locums and short-term placements to encourage physicians to consider rural medicine as a career trajectory.
- Motivate medical students and new graduates to consider rural medicine by emphasizing the unique advantages and incentives of becoming a rural physician.
- Expose rural secondary school students to the possibilities of a career in rural medicine and build enabling pathways to support those who choose to pursue this through programs such as the UNBC Healthcare Travelling Roadshow, REAP's High School Strategy, and Selkirk College Rural Pre-Medicine program.

Data also indicated where there are current gaps in supports available to new to rural practice (NTRP) and prospective rural physicians. Findings suggest that educational and rural support programs should consider:

- Providing (and incentivizing use of) supports to mitigate burnout and foster resilience among rural physicians. Existing programs include the RCPD Coaching and Mentoring Program (CAMP),

Clinical Faculty Mentoring, and Cognitive Behavioural Therapy (CBT) Skills Physician Wellness Group Training.

- Prioritizing continued medical education and professional development content that (a) aligns with topics of interest for rural physicians (e.g., business skills for running a clinic, population health topics, cultural competency), and (b) supports shifts in workplace culture (e.g., challenging self-sacrificing narratives by normalizing expectations to ask for support).
- Creating more comprehensive short-term supports for physicians during their transition to rural communities (e.g., access to a community liaison to facilitate moving and settling in, peer mentorship that is practice-specific, “buddy” shifts for emergency medicine, access to personal learning plans, and an orientation manual with human resources related information and a contact).
- Extricating funds for rural physicians to problem-solve, access administrative support, and pilot innovative community health initiatives that respond to population needs. Existing initiatives funded by the Joint Standing Committee on Rural Issues include the Rural Continuing Medical Education (RCME) Community Program, Rural Obstetrical and Maternity Sustainability Program (ROAM-SP), and Rural Surgical and Obstetrical Networks (RSON).
- Facilitating better access to medical school for rural community members by eliminating barriers to entry – especially for Indigenous youth and first-generation university students. Existing programs supports include the Indigenous MD admissions committees and interviews with an Indigenous Interview Panel, Indigenous Pathway to the MD Undergraduate Program at UBC, Medicine Cousins mentorship program at UBC Faculty of Medicine.



# Introduction

Rural communities offer unique career advantages and incentives for physicians, including: competitive salaries and financial incentives, strong professional networks, shared responsibilities, team-based care, and diversity in day-to-day medical practice. Yet, rural communities struggle to recruit and retain physicians, making continuity of care a challenge. As more rural physicians retire, finding emerging physicians to take over existing practices - or start new ones - is a priority for rural and remote communities.



This study seeks to address this challenge by understanding:

- What factors encourage physicians to work in rural communities
- How programs focused on rural practice can support NTRP physicians to prepare for and stay engaged in rural medicine on a long-term basis.

In the spring of 2020, the University of British Columbia's Division of Continuing Professional Development (UBC CPD) partnered with the Rural Coordination Centre of BC (RCCBC) to explore these questions. The New to Rural Practice research project aimed to understand tangible steps, mechanisms, and strategies for rural practice preparation programs to improve the transition experiences for NTRP physicians. To do this, the research team aimed to:

1. Co-develop and conduct a study to investigate the effectiveness of existing supports and programs for new to rural practice (NTRP) physicians in BC
2. Provide recommendations to funding agencies, policy makers, and NTRP programs in BC
3. Refine program design and delivery iteratively based on project insights about the challenges and successes experienced by NTRP physicians

By generating insights into community integration experiences for physicians in early stages of their rural practice, this study informed recommendations (page 23) about ways to better recruit, retain, and support physicians in rural communities across British Columbia.

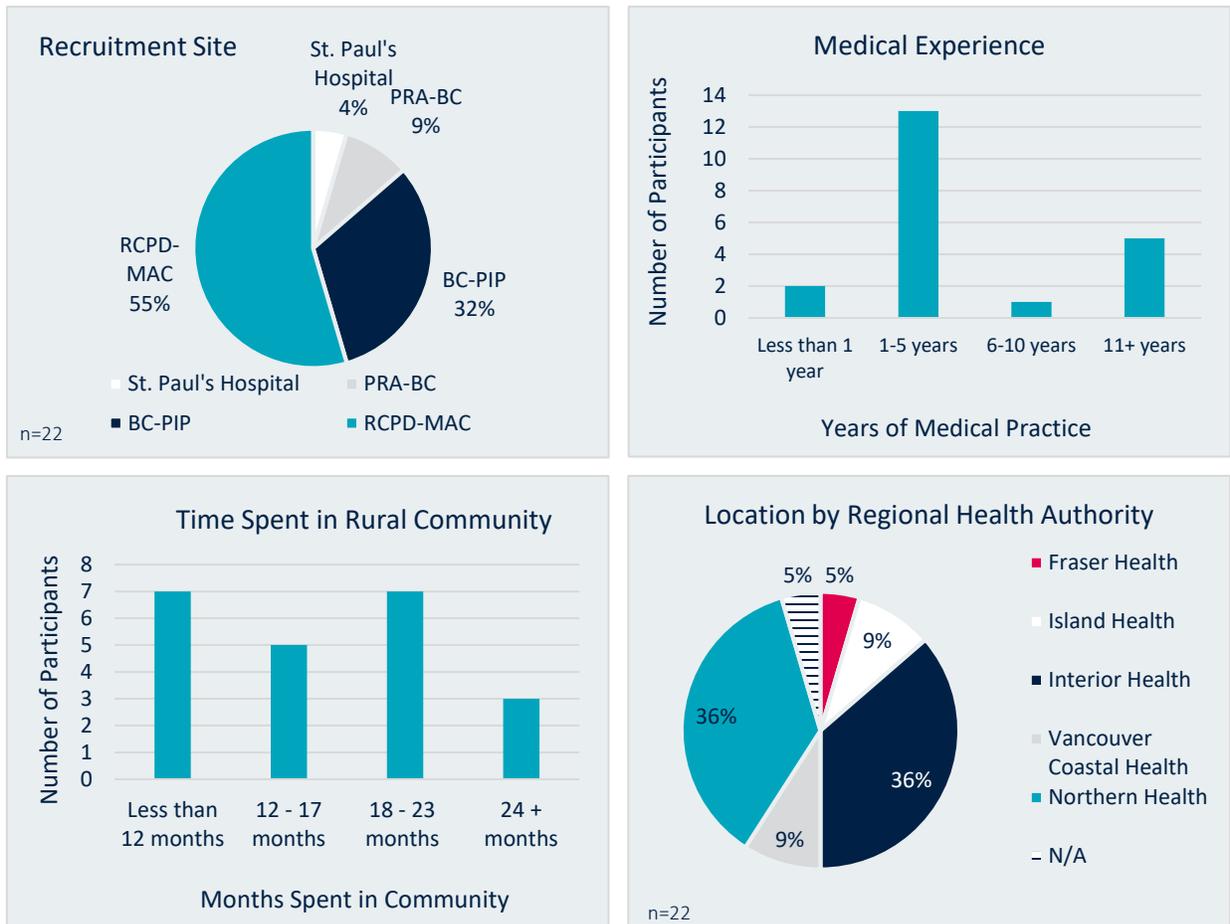
# Methodology

This project was guided by two research questions:

1. What are the experiences surrounding the transition into a rural BC community for physicians?
2. What are the perceived barriers and enablers that physicians experience when integrating into a new community?

## Recruitment and Demographics

NTRP physicians (n=22) were recruited to this study through programs that prepare new to practice (NTP) physicians for practice and were based across diverse BC regional health authorities.



Participants' years of medical experience ranged from 8 months to 32 years with the majority of physicians being in the early stages of their career (5 years or under). At the time of interviewing, participants were between 6 and 26 months into their rural community practice (Mean: 14 months, Median: 13.5 months). Physicians who were at least six months into full time rural practice were intentionally recruited as it was deemed beneficial for the subjects to have some experience prior to the

interview. Interviews were also limited to those who had less than five years of experience to reflect their experience as an NTRP physician. All participants identified as family physicians. Some had additional areas of specialty (e.g., OBGYN, emergency medicine, sports medicine). Just under half of the participants were International Medical Graduates (IMGs) (n=10) and over half were Canadian Medical Graduates (CMGs) (n=12). At the time of interviewing, 14 participants identified as male and 8 identified as female. No other demographic information was collected.

## Qualitative Interviews

Participants took part in 1-hour semi-structured qualitative interviews (see Appendix A on page 28 for the interview guide) with the research assistant over Zoom. In some instances, a physician consultant co-interviewed participants with the research assistant. Interviews focused on changes in confidence since transitioning into rural practice, the scope of medical practice included in physicians' day-to-day responsibilities, available medical supports, access to resources (e.g., training and education materials or connections to specialists), and motivators or facilitators that enabled them to transition. Honoraria of \$160 were offered as a token of appreciation for their time. Interviews were recorded on Zoom and transcribed.

## Data Analysis

Data analysis was completed in its entirety by independently contracted researchers. Qualitative data were coded using a deductive thematic approach. A priori codes were identified based on the Continuing Professional Development (UBC CPD)

team's priorities and the interview guide. Two contracted researchers coded the transcripts independently and compared coding to promote inter-coder reliability. A third independent researcher reviewed and verified consistency and quality of coding. Codes (see page 30) were categorized into three overarching themes to explain the relationships between codes. The overarching themes were as follows:



- Career planning and preparing for success in rural practice
  - Proactive steps physicians took to (a) transition into rural communities and (b) align their practices with their career ambitions
- Career satisfaction in rural practice
  - Factors that influenced physicians' satisfaction with rural careers once settled in the community
- Living and belonging in rural communities
  - Factors outside of work that contributed to physicians' sense of permanence in rural communities

The independent researchers engaged the UBC CPD team in multiple rounds of feedback to align the final report and its recommendations with stakeholder priorities. After completing the data analysis, drafting recommendations, and writing up the findings, the independent researchers turned the report over to the UBC CPD team. The UBC CPD team then solicited feedback from across its research team members and made iterative changes to the data analysis, discussion/conclusions, and recommendations sections in the report to incorporate the feedback.

## Findings

### Career Planning & Preparing for Success in Rural Practice

Participants indicated that feeling adequately prepared and confident to practice the full scope of rural practice informed their decision to move to a rural community and subsequent career planning. For some participants, preparing for rural practice began in medical school whereby additional courses and training outside of the medical school curriculum helped them to become self-sufficient. Once settled into a rural community, participants explained that community-specific medical training was necessary to respond to unique population health needs, keep skills updated, and manage the day-to-day of emergency and routine clinic work.

Participants who planned their careers around rural medicine emphasized that rural-focused education and training (in medical school, on-site in rural communities, and through Continuing Medical Education (CME) courses) would help future cohorts of medical graduates to consider rural medicine as a viable career option.

### Education

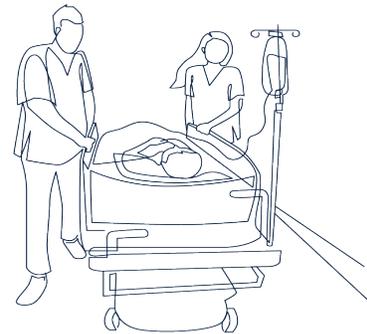
Education was central in participants' career planning for rural medical practice. IMGs and CMGs alike emphasized the importance of becoming self-sufficient and meeting the anticipated needs of rural and remote communities. For CMGs in the study who grew up in rural communities and already had a strong desire to work in rural or remote areas, medical school was an important time to participate in a broad spectrum of courses and training to prepare them for rural medicine. For participants who grew up in a rural community this exposure enabled their career planning to begin much earlier than other participants.



Most participants described up-skilling after settling in to their community. Primarily, participants' initial learning curve was tied to learning about policies and procedures related to running a clinic (e.g., billing, managing patient transfers, and navigating organizational and place-based policies). While physicians (both IMGs and CMGs) who already had experience working in BC were familiar with navigating health

authorities and provincial policies, IMGs who were new to BC explained that programs like the Practice Ready Assessment – British Columbia (PRA-BC) and British Columbia Physician Integration Program (BC-PIP) were highly valuable. For instance, two physicians who are PRA-BC graduates considered this program to be an excellent source of resources (guidelines and important websites) that they could regularly consult. Participants who identified as being more transient in their practice (e.g., splitting contracts between multiple communities, completing multiple rural locums, and working on short-term contracts) explained feeling frustrated by minor inconsistencies in policies or procedures between similar clinics. These participants explained that re-learning organizational practices at the start of each new contract was time-consuming and diverted their attention away from both treating patients and becoming accustomed to their new location. Some participants, however, noted that transitioning into a rural or remote community is a transferable skill; once physicians understand what is expected at the start of new contracts, the learning curve becomes more specific to differences in provincial standards or regulations. To help lessen the burden of initial learning curves, CMGs and IMGs alike expressed interest in more entry-to-practice trainings or rapid refresher resources.

After overcoming their initial nerves, participants were better able to identify (a) unique community health needs, and (b) additional training that they would need in order to address service and care gaps. Many participants described a desire for CME programs to maintain their skills. Despite practicing a wide scope of medicine, some participants explained that the specific community's needs narrowed their scope of day-to-day practice and decreased their confidence to conduct other procedures. This was common for participants working in areas with aging populations or where other health care professionals may take on additional care responsibilities. For example, many participants described losing confidence with placing IUDs or intubating patients. Independent learning options were therefore described as valuable ways to supplement on-site training.



A variety of CME opportunities are available to rural physicians. UBC CPD Personal Learning Plans provide a personalized concierge service specifically to support NTRP physicians to develop a customized menu and plan for CME. A similar service, RCME community concierges, support groups of physicians to identify common learning needs and opportunities. Through the rural peer support network at UBC CPD, physicians and maternity teams can access in-community, out-of-community, or virtual coaching. Customized training is also available through UBC CPD's simulation, virtual rounds, and hands-on ultrasound courses.

Some Indigenous organizations also offer CME for physicians. For example, Carrier Sekani Family Services offers [Nowh Guna' "Our Way" Foot in Both Worlds Carrier Agility Training](#). The Central Island Division of Family Practice and Nuu Chah Nulth Tribal Council offer cultural safety and humility training for physicians practicing in central Vancouver Island.

While most participants were interested in CME, many described three main concerns related to their ability to access the required training. First, some CMGs described rural practice as absent from medical school curricula. The contexts that they were familiar with as students working through case studies were dominantly anchored in urban settings. Guest lecturers, professors, and attending physicians were almost always established in urban clinics. To this end, CMGs without pre-existing ties to rural and remote communities explained that they did not learn about, or begin to consider, rural medicine as a career path in medical school. Therefore, medical school was seen as a missed opportunity to begin their rural/remote-readiness training.



Second, participants described barriers to accessing CME initiatives. Most commonly, rural physicians identified challenges with the location and timing of programs. Participants were not interested in spending their weekends, evenings, or valuable face-to-face patient time on professional development. Travel to urban areas was also perceived as aggravating – especially for remote physicians. Many participants were unaware of existing rural-specific CME courses and programs, and instead felt that offerings disproportionately catered to urban physicians. Participation in CME courses was most limited for IMGs who described more competing demands on their time than their CMG counterparts. Specifically, IMGs described having to choose between either dedicating time to CME courses or completing required exams and certifications. It was not possible for them to manage both CME participation and exam preparation during their transition, forcing many to choose between competing priorities.

Third, considering COVID-19 restrictions on travel and in-person gatherings, some participants explained that online education platforms levelled the playing field for urban and rural physicians to participate in



CME courses. However, after a year of online learning and experiences of screen fatigue, rural physicians were not enthusiastic about continued online delivery of educational content. Instead, participants expressed interest in alternative modalities, including: in-person in rural communities, asynchronous (i.e., podcast-style audio recordings, self-guided modules, and virtual simulations), and in-depth explorations of community-specific health topics.

## Locuming and Building Familiarity with Communities

Most participants completed residencies and/or locums in rural areas prior to longer-term contracts. These placements were primarily seen as a helpful trial period to both explore rural practice and gain on-site training. For example, several participants reflected on initially being doubtful of rural careers as they had concerns that it would be similar to medical school: *not having a work-life balance*. During locums, however, participants were able to:

- Advocate for preferred scheduling by asking for advice
- Solve complex health problems by collaborating with teams of allied health professionals or job-shadowing senior physicians
- Take on leadership roles by relying on their instincts rather than depending on an attending physician.



These experiences helped most physicians in this study overcome initial fears about workload or isolation, and to find their comfort in rural medicine.

Participants had mixed feelings about locuming across many rural communities or focusing on one place. Some participants had positive reflections about completing multiple rural locums. They emphasized the importance of coming to a community prepared with an existing professional network, group of friends, and knowledge of community norms (e.g., grocery store hours, best hiking trails). Some participants who completed rural locums outside of their current community described feeling more confident about their suitability because they had other experiences from which to compare. Other participants, however, felt that locuming in different communities was exhausting. Starting over in each new community, re-learning clinic and community-specific policies, and making new connections was viewed as stressful and added challenges to their transition. Participants identified two suggestions to potentially improve the link between rural locum placements and long-term retention of rural physicians:

1. Creating an onboarding/orientation handbook as a living resource with information related to the human resources side of their practice (i.e., guidelines for consultations, emergency procedures, referral patterns and operational logistics, available funds for community engagement, billing information, scheduling options, and tips for negotiating their ideal contract) and contact information of someone to ask for help.
2. Offering “buddy locums” – paired or group placements that encourage more physicians, especially NTRP, to form lasting relationships and remain in their community. Participants who had overwhelmingly positive locum experiences explained that completing placements with a small group made staying in the same community more desirable; if one person from the group wanted to stay, more members of the group would too.

Most participants explained that their sense of purpose as rural physicians was deeply tied to (a) positively impacting communities, and (b) filling gaps in available services. Each participant expressed a desire to provide the best possible care to all patients in their community, though they acknowledged that they could not achieve everything alone. Many participants also explained that because rural medicine requires physicians to be self-sufficient, resourceful, and independent, strategic career planning and confidence-building is important.

## Motivators and Ambitions

Participants shared three common motivators that pushed them to pursue rural medicine:

1. Opportunities for career advancement
2. Options to pursue special-interest projects or areas of passion
3. Workplace environments conducive to collaboration and learning.

Participants further reflected that the flexibility in rural medicine was a catalyst for:

1. Autonomy in their decision-making
2. Frequent offers to take on leadership roles
3. A range of choices for support (mentorship, buddy shifts, collaborations)
4. Flexibility in team dynamics
5. Funds/time available to invest in community projects or professional development

Despite initial feelings of being overwhelmed by possibilities, rural physicians also discussed finding their confidence and becoming more strategic in their career planning by using the flexibility of rural practice to their advantage. For example, some participants adapted longstanding clinic practices to better suit the community's needs. Others developed their own initiatives to address specific health topics such as mobile health or community outreach programs. One participant became more selective in both patients and areas of practice to tailor their medical practice to ensure optimal overlap of their own clinical interests and community health needs. These kinds of options helped participants to feel confident in their decisions to pursue rural medicine.



Some participants additionally expressed more altruistic motivations. Specifically, CMGs who grew up in rural communities felt a deep responsibility to return home and give back. Other participants discussed the known issue of burnout among rural physicians and felt motivated to support their peers with physician capacity. These physicians described taking over practices from retiring physicians or sharing responsibilities with under-staffed clinics in other communities through multiple part-time placements. In these cases, career ambitions were deeply tied to a sense of duty to one's professional obligation.

## Career Satisfaction in Rural Practice



From providing continuous longitudinal care for regular patients, to treating acute and unpredictable illnesses and injuries, rural family physicians are seen as generalists. Participants identified that the vast scope of practice was a key factor in their overall career satisfaction. With fewer specialists and staff in their team, physicians described becoming nimble and agile in their work. Maintaining both general practice and emergency skills led to increased feelings of confidence in their medical practice and overall satisfaction in day-to-day work. The “weird and wonderful” of rural medicine, as described by one participant, keeps physicians occupied whether in clinic, the emergency room, or other care settings. While the exciting aspects of rural medicine contribute to positive day-to-day experience for physicians, it is the rewarding interactions with patients, supportive and high functioning teams, and flexible options for practice that contribute to decisions to stay in rural communities longer-term.

## Benefits of Rural Practice

Participants frequently connected career satisfaction to a positive transition experience, explaining that starting out as a rural physician in a well-established clinic made it easy to settle in. Supportive primary care teams with long-standing rapport between nurses, allied health professionals, and non-medical clinic staff fostered more effective transitions that were considered welcoming. According to participants, welcoming team dynamics and camaraderie among staff were most-often facilitated by the following factors:

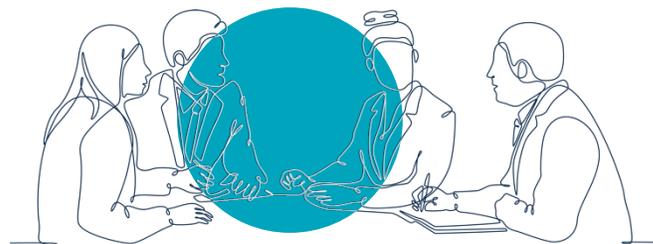
- Pre-existing relationships developed through locums, residency placements, and networking (both formal professional network connections and informal “friend of a friend” connections)
- Supportive workplace policies or practices that encourage buddy-shifts, peer support, mentorship, and ample opportunities to ask questions about both medical practice and the business side of practice (e.g., negotiating contracts, billing, taking time off)
- Friendly, uncompetitive, and unpretentious dynamics among colleagues (e.g., clinics where physicians are friends with custodial, kitchen, and other non-medical staff)
- Support from colleagues for non-clinical issues (e.g., finding housing, understanding grocery shopping options, setting up children at schools, and helping spouses find work)

“*Something for everyone*” was a mentality expressed by most participants when describing how rural and remote communities can accommodate physicians’ diverse professional goals. Whether they prefer practicing in smaller and isolated communities with few staff, medium-sized communities closer to regional hubs, large teams overseeing complex health issues, collaborating on provincial initiatives, or working primarily from a desk, participants enjoyed autonomy in their professional practice while having the opportunity to collaborate and share practice responsibilities with their fellow team members. Thus, rural and remote communities offer physicians a range of experiences and types of medical practice.

## Pull Factors: What Makes Rural Physicians Stay

Distinct from their initial motivations to work in a rural setting, participants described aspects of rural practice that encouraged them to stay for longer periods of time. One of the most significant pull factors was the ability to grow into the kind of physician they aspired to be in medical school. Solving unique and complex problems, making a difference in communities, and having positive relationships with patients were the most frequently identified factors that contributed to their plans to stay. Some participants described how the intimacy and familiarity of rural communities meant that they had positive interactions with patients outside of clinics, such as in grocery stores and in recreational groups. One participant explained that since childhood they have aspired to be a physician who performs home visits. While their urban residency and training did not allow for home visits, their rural contract enabled the type of practice to do home visits. These dynamics added depth to the physician/patient relationship making participants feel that they could meaningfully influence the health of those around them.

Flexibility in scheduling also made rural practice more desirable. Options for part-time or custom hours meant that participants could build their schedules around their own long-term needs. For some physicians, this meant being able to undertake two part-time rural placements and work in neighbouring communities. These participants explained how multiple roles provided opportunities to build familiarity across diverse populations, areas of medicine, and effective ways of running a clinic. For both experienced and NTRP physicians, flexibility allowed for recreation, hobbies, and family time. Time off was seen as critical to rural physicians.



Supportive workplace culture, close relationships with nurses and allied health professionals, and deep bonds with fellow clinic staff made it easier for participants to stay in the same community. These relationships made physicians feel more connected to their clinics and teams – discouraging them from leaving. Physicians frequently discussed not wanting to abandon their colleagues. For some CMGs, the bond with peers from medical school or previous locums/placements was a significant motivator to remain a permanent team member. While the COVID-19 pandemic negatively impacted many physicians

in their ability to build new relationships with colleagues (e.g., limited in-person and after-hour gatherings), many physicians chose to stay in the same community for the duration of the pandemic. This led to a heightened sense of permanence. Of these participants, a handful explained feeling grateful for the opportunity to get a sense of a longer-term placement. Moreover, experiencing the challenge of the pandemic with a team solidified relationships and made many participants feel integral in the clinic team.

## Obstacles, Challenges, and Barriers

Notwithstanding the importance of career benefits and satisfaction for rural physicians, many participants described persistent and unanticipated challenges that contributed to feelings of career dissatisfaction. Unsurprisingly, burnout was the most significant challenge experienced by rural physicians. Some participants described burnout as an inevitability of rural medicine. With more responsibility for handling complex health issues, fewer resources, and more remote locations, participants explained that rural physicians often are overburdened. As one physician explained,



“I would never abandon a community in the middle of a crisis, but as soon as it's appropriate for me to leave, I would leave...and I think that attitude would be potentially echoed by other people in my age group who have watched older physicians sort of lose their lives to this.”

Resulting from higher frequencies of individual burnout, participants described a cascading effect caused by rural physicians giving up their practices and/or moving away. When one physician leaves, others take on more work to: (1) cover extra shifts, (2) transition care plans for existing patients, and (3) train new locums or NTRP physicians. The excess work leads to heightened feelings of burnout for remaining physicians – decreasing their desire to continue working in the community.

Many physicians explained that the solution to the issue of burnout is to train and onboard more permanent physicians and locums into their practices. Yet, none of the physicians interviewed identified having the capacity to recruit, onboard, or train incoming physicians themselves. Instead, they unanimously described a trend whereby rural physicians start their placements amid staffing turnover with little support. As such, urban health clinics can become a more desirable choice for physicians looking for stability in both their workplace and workload.

Burnout was further amplified for rural physicians by the lack of medical resources and support for patients with complex needs related to mental health, substance use and addictions, and trauma. Often taking the role of first responder, participants described treating patients with acute mental health issues, which contributed to their own experiences of trauma and emotional fatigue. Some participants recalled helpful information about the history and grim realities of the opioid crisis in BC being taught in the PRA-BC and BC-PIP programs, making it easier to prepare for to work in communities most affected by addictions. Few participants identified having concerns about their own mental health. Instead, some expressed overly confident statements about being able to *tough out* difficult work or sacrifice their own

wellbeing to help patients. Data from these interviews indicated that ongoing training and strategies for handling trauma would be beneficial for rural physicians. Even though much more is needed, some emerging programs aim to address these needs and viewed as potential future support for those NTRP. For example, the BC Ministry of Health Physician Health Program has developed guidelines related to physician burnout. The Program has also developed supports for physicians managing clinical work with motherhood.

Another challenge for rural physicians was accessing support from specialists outside of the community. Little awareness of rural contexts among urban specialists caused frustration for participants who described having to work harder to find answers and options for their patients. For example, one physician described spending a full day



attempting to contact a specialist, after which they were informed that the patient would need to travel to Vancouver for answers. Despite explaining the long distance and unaffordable cost of chartering a plane for a patient to make the appointment in time, the physician was not given alternative options or further support. Similarly, some participants described negative interactions with specialists who were frustrated, annoyed, or even angered by requests to help with complex health issues. Physicians working in the most remote areas had negative experiences with specialists who did not have any comprehension of the rural medical environment.

Most participants remedied issues related to accessing a second opinion or specialist perspective with real-time virtual support programs (i.e., ROSe, RUDi, CHARLiE, MaBAL) funded by the Joint Standing Committee on Rural Issues, which provided them with knowledge that support was available if required. These virtual supports were most utilized by rural physicians during emergency room shifts. For them, quick and easy access to another medical opinion helped to increase their confidence and provide comprehensive care for patients with complex health issues. Many participants explained that they have a preferred specialist they would initially attempt to contact, and viewed virtual supports as an alternative option that they have rarely used. A small number of participants (n=2) had negative experiences with virtual supports – they called the virtual support but no one answered making them feel alone. Negative experiences contributed to their overall sense of disappointment and frustration in being unable to provide high-quality care to rural and remote patients.

Though weighing less heavily on rural physicians, other minor day-to-day aggravations also accumulated into descriptions of career dissatisfaction. IMGs specifically experienced increased administrative barriers in becoming established in rural areas. Many described frustrating and time-consuming experiences of scheduling and writing qualifying exams, applying for the right certificates, and processing various medical licenses. In some cases, administrative barriers were worse outside of Vancouver due to inability to attend in-person meetings, file paperwork, or take an exam. While many physicians described the perks of rural incentives, such as higher salaries and more paid vacation, they also described higher living costs, especially in Northern and fly-in communities. Factoring in higher costs of living in BC compared to

rural communities in Alberta or Manitoba, some physicians - especially those with student debt - questioned if the financial incentives were sufficient.

## Living & Belonging Rural

For participants, being a rural physician was tied to more than their medical practice. Living and participating in a rural community – time off, settling in, connecting to the physical place – were important factors in participants’ decisions to stay long-term in the rural community. Consequently, feeling isolated, lonely, and self-sacrificing contributed to physicians’ readiness to leave. For physicians with families and spouses, decisions about where to live also had to accommodate the needs of others.

### After Hours

Because of the flexibility in rural physicians’ schedules, many participants discussed the importance of balanced after-work activities. For example, most participants were outdoor enthusiasts. Flexible hours and ample time off were conducive to engagement in recreational activities and hobbies. While many physicians described initially needing help from colleagues to advocate for and set up flexible schedules, most were satisfied with their work life balance. For early-career physicians especially, the concept of time off – something often disregarded during medical school – was a welcomed change of pace. Rural practice was therefore seen as a good fit for physicians also interested in an active and adventurous lifestyle.

### Establishing Roots in the Rural Community



Family was the most significant factor influencing physicians’ decisions to stay in a community. Participants with strong pre-existing family ties to the community were generally the ones who indicated a definitive decision to stay in their community permanently. Physicians who grew up in the same community explained that leaving for school, locating in neighbouring communities, and returning for a full-time and permanent position was

always their intention. Those with partners and/or relatives in the community also felt stronger ties and a sense of permanence. For these physicians, the decision to practice in the community centred on their ability to be at home.

Correspondingly, children and family planning influenced physicians’ decision-making. Participants with young children preferred to work in a community where their children could flourish. Not wanting to disrupt children’s ability to make friends, build familiarity with a consistent school, and participate in community life (e.g., extracurricular activities) was viewed by some physicians as a reason to stay in a rural community for a longer period of time. Similarly, because establishing a new practice in a rural community requires



significant time away from family, physicians working extra time during this initial period felt that they owed it to their families to remain in the community. Not uprooting their family again meant that they could avoid additional time away or missing key milestones in the lives of young children. Physicians who shared this perspective reflected that after their offspring graduate from high school, they might consider a change of location. Those planning to have children in the next few years described the importance of working somewhere with high quality reproductive, maternal, and child care. Some participants, namely primary care obstetric providers, raised the concern of their ability to access adequate sustainable obstetric care if they themselves became patients. Career planning and family planning were therefore deeply intertwined for physicians, especially in the early stages of their careers and families.

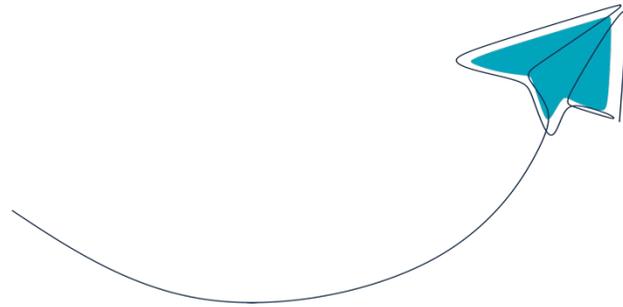
The career ambition of participants' partners was another important factor. Some participants described having partners whose career preferences were conducive to rural settings (e.g., fishing, construction, consulting). These physicians explained that their medical career determined where they would settle as a couple. Other physicians, however, described their partners' careers as a potential barrier for rural practice. Specifically, partners with competing career ambitions and highly specialized skills made it harder for physicians to work in a rural community and live with their partner. For example, one physician explained that their spouse was a university professor before they moved together to the rural community. Without a university in the community or opportunities to be a professor nearby, it was difficult for the spouse to find meaningful employment. Many physicians were married to fellow NTRP physicians, who were also navigating career planning, locuming, rotating placements, and further training. For one physician married to a physician working in Vancouver, it seemed likely that, in time, they would transition to urban practice. To accommodate conflicting geographical needs of partners, some physicians made their relationships work by living together part-time and/or pursuing long-distance arrangements. This was not seen as a favorable or permanent solution for most participants. The distance and career sacrifices of one partner to support another seemed to be a point of tension for most physicians. Ultimately, physicians explained that the decision to stay long-term in a rural community would need to be advantageous for both partners.

## Enablers of Transition Out of Rural Practice

While physicians explained the many reasons to stay in a rural community, they also shared challenges of rural living that might encourage them to leave. First, being able to establish a feeling of being at home was significant in physicians' decisions on whether to find alternative contracts and leave. For IMGs, housing was a significant challenge. Understanding the limited and competitive BC housing market was a huge learning curve for physicians and their families upon arrival. Only being able to find suitable housing at certain times of the month, not knowing how close housing would be to their medical practice and community amenities, and finding the right type of unit for a family were just some of the unanticipated challenges that made rural living more difficult. Physicians transitioning to rural communities with families, specifically male participants with female partners, described feeling guilt for relying on their partners to find housing with limited help while they focused on work. This dynamic was described as a source of strain on the relationship. Second, community amenities, especially related to food options and availability, was an important factor. For example, one physician worked in a community without a

grocery store and was not given adequate notice to do their shopping ahead of time. As a result, they bought groceries from a gas station for the duration of their placement, which lacked fresh food and nutritional options. Finally, an overall sense of belonging was important for physicians settling in to a community. Those who wanted to feel connected to others through common interests, religious or spiritual ties, cultural groups, and romantic pursuits were often disappointed when they didn't feel that the community offered meaningful connections. Some physicians explained this feeling as *sacrificing* relationships and geographical proximity to community for work.

Without feeling connected to others in meaningful ways, physicians described the desire to leave the community and move to another location.



## Discussion

### What it Takes to be a Rural Physician

While there is no definitive mechanism for success, data suggest that physicians who pursue meaningful and long-term careers in rural medicine had:

- Confidence in their abilities to work independently while contributing to close-knit teams
- Passion for problem-solving and addressing complex health issues
- Career satisfaction in the work they do and their work/life balance
- The tenacity to persist with, and create, a unique career path
- The professional humility to step back, ask for help, learn more, and try again
- Something beyond work keeping them connected to place and community

While physicians in this study frequently commented on the challenges of being in rural medicine, they also seem to thrive in the uncertainty and variable nature of the clinic environment. Most participants demonstrated creative problem-solving skills by detailing how they consistently overcome or embrace barriers by constructing their own path. From listening to CME audio recordings while commuting to patient visits, to finding ways to meaningfully converse with urban specialists, these rural physicians are determined to succeed.

Data also suggest an important connection between rural physicians' values and deeper sense of purpose. Altruistic motivations to support patients with limited options, improve quality of life for rural communities, relieve colleagues from onerous responsibilities, and support their own families seem to

facilitate longer-term periods in rural and remote areas. Indeed, even if physicians are not fully satisfied with their current work, they often felt responsible to stay rather than abandon their colleagues or patients. Some rural physicians internalized a belief that being a good physician requires self-sacrifice. Data illustrates a clear difference between physicians who perceived rural practice as a barrier to or facilitator of relationships, sense of belonging, and feelings of community connections. Those who are committed to long-term rural practice did not view their practice as a sacrifice, but rather as one with many important ties to community.

Rural practice is not without unique challenges. Data indicate that burnout among rural physicians is inevitable. Thus, even if rural physicians have the determination to stay with a practice longer-term, the scope of responsibilities; limited resources; and mental, emotional, and physical exhaustion could contribute to a shorter overall career.

Other nuanced issues and noteworthy silences in interviews also pointed to challenges related to inequities in medicine, which are historically prevalent in many BC communities that are geographically far away from large health centres with the problems being most pronounced in Indigenous communities. While not explicitly stated by participants, some reflections indicated a lack of cultural competency and diversity training among healthcare providers, especially those who work closely with Indigenous and prominent newcomer, immigrant, and refugee groups. Many physicians described rural communities as lacking resources and supports for female, transgender, and gender diverse patients. Not being able to offer sound gynecological, sexual, and reproductive health services was a common theme in interviews. These data indicate that there are practice gaps and larger systematic issues that impact the health of rural populations.

## Opportunities for Future Inquiry

This project illustrated the importance of inquiring into physicians' experiences and perceptions of rural practice to understand which factors contribute to their decisions to stay in communities on a long-term basis. Current data can be used to inform decision-making around educational content development (e.g., professional development curricula geared towards rural medicine), incentivizing and advertising rural placements, and bolstering supports available to rural physicians.



Future studies may look at collecting more demographic data related to participants' identities and backgrounds (i.e., years of clinical practice, country of origin, ethnicity, and marital status). Future research would benefit from (1) being able to situate participants' responses in a demographic context, and (2) including interview questions about personhood, belonging, safety, and identity to ground recommendations in a commitment to diversity, equity, and inclusion.

# Recommendations

The following recommendations were developed by the study research team and the external research consultants. They stem from the data generated through interviews as well as perspectives of the research team including staff members at UBC CPD and physician consultants practicing in rural BC.

## Recruitment

Data suggest that the recruitment of NTRP physicians to rural and remote communities in BC could be enhanced by:

### 1) Emphasizing the unique aspects of rural practice both during medical school and when searching for employment.

- Combat the negative perception that rural practice leads to burnout by elevating strengths and exciting opportunities inherent in rural practice, such as:
  - More autonomy in medical decision-making
  - Broader scope of practice
  - Incentives such as: financial benefits, flexible scheduling with full-time and part-time opportunities, leadership opportunities,
  - Community, peer networks, and a sense of belonging and integration
  - Reasonable work hours
  - Recruitment narrative around enhancing care within a community rather than saving a community
- Understand people's values and deeper sense of purpose to increase motivation for rural work, including:
  - Opportunities for holistic and longitudinal care of regular patients (e.g., home visits, outreach, and community-based care)
  - Complex problem-solving related to acute, unpredictable, and population-specific illnesses and injuries
  - Positive relationships with patients in and outside of the clinic
  - Proximity to nature, outdoor recreation, a slower pace of life, and support to balance career and family/life goals
- Overcome fears of isolation and being new to rural practice (especially for NTRP and NTP physicians) by highlighting:
  - Exceptional opportunities for mentorship from senior physicians, specialists, and allied health professionals
  - Friendly and closely connected medical community and working environments (e.g., access to RCPD's Coaching and Mentoring Program)
  - Available support for professional development, upskilling, and career advancement (e.g., the Rural Education Action Plan's Advanced Skills Training funding support, shorter routes to leadership positions, and opportunities to lead special-interest projects).
  - Accessible virtual supports (e.g., RUDi, ROSe, CHARLiE, MaBAL)

- Supportive relationships with referral hospital specialists including opportunities for networking during the orientation period

## 2) Encouraging and incentivizing participation in (a) rural locums for highly experienced and early-career physicians alike, and (b) rural clinical placements for medical students

- Continue to strengthen networking, mentoring, and coaching initiatives that connect prospective and incoming rural physicians with more established rural physicians who are aware of locum opportunities and/or may be retiring and seeking physicians to supersede them in their practice
  - Support retiring rural physicians to (a) advertise job postings, (b) connect with interested applicants, and (c) coordinate their transition out of practice to overlap with incoming physicians' entry into communities. Ensuring that incoming physicians can benefit from the expertise and mentorship of outgoing physicians before they leave may enhance institutional memory and the transition experiences for both new and retiring rural physicians. One avenue for this is a living community handbook with contact information of outgoing physicians; the RCCbc Community Map online resource, which has content on each community including demographics and clinic information, is an existing resource that can be expanded.
- Elevate positive lived experiences of NTRP physicians through network or alumni profiles and/or short online stories (e.g., ask a rural doc anything, five reasons to consider rural medicine) that highlight first-hand experiences, compelling stories, and advice. The RCCbc's Enews page on their website or monthly eNewsletter (BC Rural Update) could be good outlets for such stories.

## 3) Facilitating better access to medical school for rural and remote community members – especially Indigenous people, young people living on reserves, and first-generation university students.

- Revamp rural outreach initiatives that (i) encourage young people from rural and remote communities to consider medicine as a career option and (ii) advocate to decrease barriers to accessing medical training for equity-seeking groups such as the UNBC Healthcare Travelling Roadshow, REAP's High School Strategy, Selkirk College Rural Pre-Medicine program.
- Prioritize recruitment of IMGs who are members of Indigenous communities in their own countries, are from rural/remote communities at home, and/or who are first-generation university graduates in their families.
- Encourage groups of medical school residents to undertake rural locums with their peers and allow flexible FTEs.

## Retention

Contribute to increased retention of NTRP physicians in rural and remote communities by:

- ### 1) Providing short-term transition support to help physicians set up successfully to both work and live in rural and remote communities.

- Offer entry-to-practice programs that (a) introduce new physicians to key processes upon arrival (e.g., referral systems and patterns, emergency care access, facility tour, EMR system, billing system) similar to some supports provided through the *A GP For Me* province-wide initiative in BC, and (b) offer a concise summary of resources available to them as rural physicians (e.g., a fact sheet).
- Broker relationships between rural/remote clinic administrators and HR specialists (e.g. from local Divisions of Family Practice or Health Match BC recruiters) who can develop a physician onboarding template that centralizes information for incoming physicians.
- Work with communities to either expand the role of rural CME liaisons or hire community transition liaisons who are familiar with the needs of both communities and incoming rural physicians and their families. These liaisons can:
  - Check in with physician before and after they move
  - Help with finding housing, enrolling children in schools/childcare, locating grocery options (if needed)
  - Support the spouses or partners of physicians to find meaningful employment and/or volunteer opportunities
  - Make personal introductions for physicians and their families to facilitate friendships

## 2) Arranging for ongoing proactive and preventative support to mitigate burnout and bolster rural physicians' sense of confidence and capacity to practice.

- Normalize conversations about and skills-building for rural physicians' mental health by including related topics in:
  - Professional development sessions that embeds wellness into traditional courses (e.g., embedding physician mental health in another topic).
  - Coaching and mentorship trainings and programs such as RCPD Coaching and Mentoring Program (CAMP), Clinical Faculty Mentoring, Cognitive Behavioural Therapy (CBT) Skills Physician Wellness Group Training (e.g., encourage mentors to openly discuss their own mental health as rural physicians and check-in on mentees' wellbeing).
- Counter internalized narratives about needing to sacrifice mental health, relationships, connections to community, and geographic preferences in pursuit of a successful career in rural medicine by:
  - Paying attention to the narratives that physician and educational organizations promote about (a) what it takes to be a rural physician, and (b) who makes a good rural physician
  - Working with rural physicians to identify narratives that are harmful and promote unrealistic and unhealthy expectations that contribute to burnout (e.g., that rural physicians must 'tough it out', choose their careers over their families, forgo romantic relationships to cover clinic shifts, put up with geographical isolation, etc.).
  - Encouraging mentors, coaches, panelists, and professional development facilitators to share their stories to combat unrealistic expectations (e.g., a time when they benefitted from asking for help, how they use their time off, a point in their career where they struggled with mental health, etc.).

- Increase awareness of centralized resource lists for BC rural physicians (e.g. RCCbc website, RCCbc community descriptions, REAP webpages) to make it easier for them to (a) become aware of available supports, and (b) understand how to access them:
  - Topics of interest include resources to: upskill, network, discuss specialty issues or complex health issues, learn about the business side of practice, manage mental health concerns, navigate time management, de-stress, advocate for time-off or preferred scheduling, manage conflict resolution, overcome feelings of isolation or loneliness, balance work/life responsibilities, be proactive about career planning, offload/mitigate workplace stressors, mitigate trauma, etc.
- Support time off for rural physicians through locum placements, enabling care teams, and promoting initiatives that offer shared responsibility of care.

## Ongoing Support

Continue to enhance and transform rural medicine and community practice by offering supports for physicians, by:

### 1) Creating new opportunities to effectively address emerging training needs of incoming and longstanding physicians in rural and remote practice.

- Continue to ensure that CME and professional development sessions are accessible in multiple formats that fit into rural physicians' lifestyles and schedules (e.g., local in-person sessions, asynchronous modules, podcasts/recordings, directed reading or self-paced content, and virtual reality simulations).
- Prioritize content related to topics of interest for rural physicians (e.g., 2SLGBTQI+ health, cultural competency and cultural safety training for working with indigenous communities, anti-oppression and anti-racism, women's health, aging).
  - Incentivize participation in equity-centered trainings by offering credits, honoraria, and/or reimbursement for incurred costs.
- Elevate offerings related to mental health and substance use so rural physicians who act as first responders in crisis situations (a) feel equipped to do so, (b) can create comprehensive care plans for patients, and (c) can mitigate vicarious trauma.

### 2) Encouraging rural physicians to innovate and problem-solve in their communities by ensuring that funds, administrative support, and in-kind resources are available for them to pilot solutions.

- Connect rural family physicians to community services (e.g., peer support programs, food banks, outreach programs, cultural health brokers) to (a) increase their capacity to deal with complex issues (such as poverty and mental health) and (b) help physicians connect patients with more appropriate supports for non-medical issues that impact patient health outcomes.
- Make administrative support available to physicians to help them manage contracts, scheduling, referrals, transfers, billing, and policy development to free-up more time for them to focus on providing comprehensive care to patients and/or innovating community-based health solutions.

- For example, consider contracting HR specialists and/or administrative assistants to streamline and provide organizational support to rural medical teams.
- Create paired or group locum positions in rural communities to: (a) combat fear of loneliness and isolation, (b) provide more comprehensive scheduling relief to current rural physicians without overburdening a single new physician, and (c) increase feelings of belonging and cohort-ties among locums to encourage them to stay longer as permanent physicians.
- Creating an avenue for rural providers to have rural-oriented, context sensitive conversations around specialized services such as programs like the Real-Time Virtual Support's pediatric (CHARLiE) and maternity (MaBAL) streams.

# Appendix A: Interview Guide

## Demographic Questions

1. Where did you complete your medical school training?
  - a. What specialty were you trained in? (i.e.: FP - Rural, Neurology, Ophthalmology, etc.)
2. How long have you practiced medicine?
3. How long have you practiced in your current community?
  - a. Is this the first community you've practiced in? (If yes, where else have you practiced?) First in Canada? First in BC?

## Transitions in Practice

4. How has your transition into practice impacted you personally and professionally?
  - a. What has had the most significant impact on the transition on your practice?
  - b. Has your transition changed the way in which you practice medicine?
5. Is your current level of confidence in your current community any different of that from your previous community? How does your perceived level of confidence practicing in your current community compare to that of your previous community?
  - a. Are there certain aspects of your practice that you feel more confident in than others?
  - b. How has your confidence changed from when you first started your practice? What aspects of your confidence have remained the same? If it improved, why or why not?

## Community Suitability

6. What steps did you take to professionally integrate into your new community?
  - a. What programs, networks, courses and organizations did you tap into to enable this integration?
  - b. Do you get enough exposure to your chosen specialty within your community? If not, what is your chosen specialty, and what offerings are you aware of to gain this exposure?
  - c. Do you think your community's needs are met with your current skillset? If not, why not? If yes, what are the different factors that you attribute this to?
7. How have your professional relationships developed over the course of your arrival in the community?
8. Can you describe any professional supports that you receive from your physician community? Please explain.
  - a. Is there anything that would increase your sense of comfort when you need support?
  - b. Do you feel comfortable asking for support from your health care team beyond physicians? For example, nursing staff, MOA, pharmacists, nurse practitioners, paramedics.
9. Can you describe your experiences integrating into your local healthcare professional team? (i.e.: physicians, nurses, and hospital staff).
  - a. Where there any challenges in this integration, and if so, what were the nature of these challenges? (i.e.: interprofessional dynamics)
    - i. Communication skills
    - ii. Professionalism
    - iii. Patient Care
    - iv. EMR, socio-technical skills

### **Educational Offerings**

10. Did you participate in PRA-BC and/or BC-PIP?
11. How did the PRA-BC or BC-PIP program impact you professionally? What was the most valuable benefit?
  - a. Have these programs affected your ability, confidence or engagement with your work? If so, how? If not, why not?
  - b. Have these programs held any impact on how you provide care to your patients?
12. (If not part of PRA-BC) Did you access any other support programs? What else have you participated in that has helped you feel prepared / what has set you up for success within your community?)
13. What keeps you up at night in regard to your practice?
  - a. What community professional and interprofessional factors affect this?
  - b. What factors would allow you to feel more confident in your practice?
  - c. Is there something that you wish existed that could improve your integration into practicing within BC?

### **Framing questions discussing Humanism, Equity and Racism (integration)**

14. (PRA-BC = assigned, BC-PIP= may have some choice) Why did you go to the community that you're located in?
  - a. (If you had the choice) Would you choose to live and/or work in this community?
15. Do you have any other feedback that hasn't been touched on already?

## Appendix B: Code List

Code Name	Description
Career Planning	Professional planning, scoping possible work opportunities, and strategic thinking related to future career ambitions or goals.
Career Satisfaction	Perceived career satisfaction - both positive (i.e., satisfaction) or negative (i.e., burnout) personal experiences or professional experiences (i.e., career advancement, alignment with goals)
➤ Dissatisfaction	Negative outcomes or experiences related to rural career (i.e., burnout, anxiety, long-term imposter syndrome, feelings of failure, lack of self-worth)
➤ Satisfaction	Positive outcomes or experiences related to rural career & ideal career goal alignment, feelings of workplace pride
Confidence in Practice	Medical experience (time spent in practice)
➤ Autonomy	Making decisions for self about one's own practice, scope of work, time off etc.
➤ Decision-Making	Making choices about care planning and treatment
➤ Learning Curve	New to practice experiences (imposter syndrome, anxiety of first-time practice)
Connections, Relationships & Belonging	A person's network, kinship, relationships, and overall sense of connection
➤ Feelings of belonging, connection, community	How a person feels in the community and their sense of connection to place (workplace and/or rural place)
➤ Isolation	Feelings of geographical and interpersonal isolation living & working rural
➤ Personal Networks	The personal sense of belonging in the community
➤ Professional Networks	Workplace, professional community (sense of belonging at work)
Education & Training	Continued training, professional development CME (continuing medical education), certifications etc.
➤ Barriers to Education	Barriers to accessing on-site or course-based training to upskill
➤ Course-based Learning	Formal courses, certifications, CMEs
– Prep for rural Practice	Learning or gaining certifications to become rural-ready or to fill gaps in expertise given fewer human resources
➤ On-site Training	"Learning by doing" or learning about being a physician by being a physician

Code Name	Description
<ul style="list-style-type: none"> <li>- Mentorship &amp; Colleague-based Learning Support</li> </ul>	On-site teaching, collaboration, and education support from colleagues or senior staff
Medical Practice	How a person practices, changes in medical practice, experiences of practice
<ul style="list-style-type: none"> <li>➤ Access to Medical Resources</li> </ul>	Supports, capacity, technology, referral system, consultation availability, accessibility of specialists, and access to treatment and testing options or facilities etc.
<ul style="list-style-type: none"> <li>- Awareness of resources</li> </ul>	How physicians learn about available options and resources as part of their transition
<ul style="list-style-type: none"> <li>➤ Difference between rural and urban</li> </ul>	Comparisons between rural practice or experiences and urban/metropolitan medical practice or lifestyle
<ul style="list-style-type: none"> <li>➤ Locums or Placements</li> </ul>	Where/how long they practice, temporary rounds etc.
<ul style="list-style-type: none"> <li>➤ Responsiveness to Community Needs</li> </ul>	Ability to best to support/ fill gaps in community care needs and orienting professional development to address them.
<ul style="list-style-type: none"> <li>➤ Scope of Responsibilities</li> </ul>	What rural physicians do (day to day responsibilities, what is in their capacity to manage in their role)
<ul style="list-style-type: none"> <li>➤ Workplace Environment &amp; Culture</li> </ul>	The organizational norms of their place, mentorship, relationships with colleagues or related care team, social interactions with colleagues above/beyond care decision-making, what is happening in care settings
<ul style="list-style-type: none"> <li>- Comradery</li> </ul>	Relationships among colleagues that are positive, based on mentorship, or include social time or networking and belonging at work
<ul style="list-style-type: none"> <li>- Conflict</li> </ul>	Interpersonal conflicts at work
Place	Geography of the community, sense of transience or permanence in the community, movement between, notions of being settled or itchy to leave
<ul style="list-style-type: none"> <li>➤ Permanence &amp; Continuity of Place</li> </ul>	Continuity or long-term placements or living situations
<ul style="list-style-type: none"> <li>➤ Transience</li> </ul>	Movement between places, temporary placements, short-term stays
Systems	Systemic challenges, contexts, or complexity of structural aspects of practice
Transition Experience	The move to a rural community for practice, change of practice, change of lifestyle etc.
<ul style="list-style-type: none"> <li>➤ Barrier</li> </ul>	Barriers to positive transition to rural practice, desired medical practice, integration into community etc.

Code Name	Description
– COVID-19	Specific barriers or challenges related to the pandemic (which will likely not be an ongoing concern)
➤ Facilitator	Facilitators or factors that enable positive transition, positive medical practice, careers satisfaction etc.
➤ Motivations	What motivates a person to practice in a rural setting or stay rural
– Perceived benefits or advantages of rural practice	An advantage, benefit, or positive outcome of rural practice   OR perceptions of unique strengths and opportunities afforded because of rural practice OR perceptions of benefits for others considering rural practice
➤ Recommendation to Improve Transition	Participant suggestions for improvement in overall experience or to address specific challenges
➤ Immigration	Newcomers’ experiences of moving to Canada and integrating into both rural and Canadian contexts (early experiences of IMGs)
Wellness	Emotional, spiritual, physical, mental, wellbeing for rural physicians (embodied impact of transition)
Work/Life Balance	Time off work, balancing personal responsibilities, personal hobbies or interests, family (and family planning) etc.