NSW RURAL DOCTORS NETWORK

Rural GPs' experiences of planning for succession

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Executive Summary

In late 2004, the NSW Rural Doctors Network developed and piloted a succession planning tool for use by rural GPs in NSW wanting to smoothly make changes in their work circumstances. Two years later, RDN interviewed the five rural GPs who piloted the tool to see whether they had chosen to implement the succession plans they constructed as part of the piloting process. Through a structured interview of 17 questions, RDN found that without any additional encouragement or support from the organisation, all five GPs had of their own volition progressed their plans to various levels, ranging from full implementation, through to implementing preliminary steps in readiness for retirement in the next 10 to 15 years.

The most consistent piece of advice offered by this GP group was that the succession planning process needs to be initiated at least two years in advance of any changes a rural GP wants to make. Indeed, one participant was of the view that succession planning should begin the day an individual enters private practice.

Among these GPs there was no support for the perception that succession planning requires excessive amounts of time or considerable expense in terms of professional advice. All found the plan could be completed in a short period so long as they put aside the time for that purpose. All five believed the outcome more than warranted the effort and any cost, and they all found they relied heavily on the valued advice of their families, friends and trusted colleagues. Four of the five found that family played a vital role in implementing their succession plan,

During the implementation process, the GPs invariably found they needed to alter or expand certain steps in their plan to suit their emerging circumstances, but none encountered any barriers to their plans that they were unable to circumvent. Further, and to the GPs' surprise, none found any unsurmountable problems in advising colleagues and the community of their plans.

The GP who had made the most significant alterations to his practice circumstances (by closing his practice, moving towns and beginning part time work in a different practice arrangement) found that the most difficult aspect of implementation lay within himself. His greatest challenge lay in initiating discussions with the other practitioners in town about his plans to leave, but once he had initiated discussions, this doctor found collegiate support where he expected barriers.

Although they were each at a different stage of implementation, the five GPs found that having a well considered succession plan allowed them to manage the change in their work circumstances in a way that took into account the needs of the key players in their communities. This fitted well with the way they wished to make these changes.

Introduction

Late in 2002, the NSW Rural Doctors Network (RDN) submitted a proposal to the Department of Health and Ageing to conduct a Succession Planning Pilot Project, the Rural and Remote Medical Workforce planning process having already identified succession planning as a major issue for rural general practice in NSW.

In April 2003, the Department of Health and Ageing contracted RDN to conduct the Rural GP Succession Planning Pilot Project utilising funding from the National Performance Pool for 2003-04.

By July 2004 a single web-based succession planning tool comprising 21 steps had been developed and during the remainder of the calendar year this was piloted by five rural GPs. The aim of the piloting process was to ensure that a variety of rural GPs could and would individually use the 21-step succession planning tool to design a succession plan for themselves in response to a range of changes they might wish to make to their working circumstances. The piloting indicated that rural GPs of both genders in a variety of practice circumstances could use the tool to produce a succession plan, which, if implemented, would help the GP alter their working arrangements while minimising disruption to general practice services in the GP's town.

Evaluation

Two years later, having had no further input on succession planning issues with the five GPs involved, RDN conducted an evaluation of the pilot process to ascertain whether plans produced using the tool could be adequately utilised to manage succession, that is, be implemented to produce a satisfactory outcome for rural communities when GPs alter their working arrangements.

The evaluation comprised a 17-question interview (See appendix 1) conducted either face to face or by telephone by the Succession Planning Project Manager. Designed to collect qualitative data on each of the GPs' experiences post-succession plan, the interview included questions on whether the GPs had implemented their plans in whole or in part, what challenges they had faced and how they had dealt with them, what role the family had played in planning and implementation, how they had informed other GPs in the town, the community and their staff, and what the response had been from these groups, their perception of the value of succession planning, and advice they might have for other rural GPs in the area of succession planning and management.

Project Objective

To assess among the GPs who piloted the succession planning tool its usefulness in managing succession in a NSW rural GP setting.

Results

To ensure that within funding limits the succession planning tool was tested by as wide an array of rural GPs as possible, the five rural GPs involved in the pilot project in 2004 were drawn from different but traditional practice circumstances (where the practice is owned and run by the practising GP or GPs), from different age groups, and from both genders, as shown in Table 1.

Table 1: Details of rural GPs piloting the succession planning tool in 2004

Gender	Proceduralist?	Age	RRMA **	Practice type
A. Female	No	Early 30s	3	Group, many practice town
B. Male 1	Yes	Early 50s	3	Solo, many practice town
C. Male 2*	No	Late 50s	5	Solo, 5-practice town
D. Male 3*	No	Early 60s	5	Solo, 3-practice town
E. Male 4*	No	Mid 50s	5	Solo, 1-practice town

* Life Partner is practice manager.

** The Rural, Remote, Metropolitan Areas (RRMA) classification classifies each Statistical Local Areas based on population numbers and an index of remoteness. There are seven categories, 2 metropolitan, 3 rural and 2 remote. RRMA 3 refers to large rural centres with population 25,000 – 99,000, while RRMA 5 refers to other rural areas with population < 10,000.

As might be expected, the GPs had different reasons for wishing to plan as indicated in Table 2.

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Table 2: GPs' succession plan aims and proposed timing in 2004 compared to outcomes by early 2007

Gender	What the GPs planned for in 2004 and what they had achieved by early 2007
A. Female	**By 2007 planned to** Reduce hours, increase leave, ?maternity leave **By early 2007 had:** Reduced surgery hours, increased teaching hours, married, planning long period of leave and perhaps maternity leave
B. Male 1	**By 2004, planned to:** Reduce hours, establish new clinic to accommodate himself and one or more other GPs **By early 2007 had:** Same hours, established new solo practice in team environment (allied health), looking to expand that model (including other GPs) in upcoming development in the town, unlikely to retire for another five years
C. Male 2	**By end of 2005 planned to:** Retire to another town via less hours (no VMO) + locum work **By early 2007 had:** Helped negotiate alternative arrangements in town, closed practice, moved to part time work in group practice in another rural town.
D. Male 3	**By 2007 planned to:** Retire in own town via less hours, recruit another **By early 2007 had:** Researched possibilities for replacement but difficulties finding replacement and buyer for practices, illness is making process more difficult
E. Male 4	**In ongoing fashion planned to:** Look at options in deteriorating practice situation **By early 2007 had:** Refurbished surgery building on five year repayment plan with a view to initiating early steps in retirement plan in about three years time

Table 2 also shows how the doctors had changed their practice circumstances between the time they made a succession plan and the time they were interviewed a little over two years later. In the interim, the GPs received no outside support or extra encouragement to implement their plans. Any changes they made were implemented using their own initiative.

The interview questions that were asked of the GPs are in Appendix 1. Their answers to those questions are summarised below.

<u>Overall progress on plans</u>

At the time of interview the five GPs were at different stages of implementation, ranging from waiting to begin in about two year's time through to one GP who was in the penultimate stages. Another had

completed the plan not long after it was made and had at the time of interview progressed to another logical extension of the original plan.

Among the changes that had been implemented (see Table 2) were:

- A change in balance of work with considerably more hours devoted to teaching
- Move of practice location to foster a close collaboration with allied health personnel, with a further plan to expand this way of working.
- Negotiation to transfer to a group practice in another town leaving in place plans for an upgrade of medical services.
- Cessation of VMO duties and investigations on selling the practice
- Refurbishment of premises with an associated plan for clearing debt

All five GPs remained working in traditional practices where the practice was owned and run by the practising GP or GPs.

Perception of the purpose of succession planning

As small business owners who had prepared a succession plan, the five GPs shared a basic view of the purpose of succession planning, namely to look to the future for themselves with their changing needs, and to do so with both theirs and their clients interests in mind.. Two of the GPs also included a more "economic" bent to their point of view – **Doctor B**, as well as seeing planning as ensuring continuity of care for his patients, also saw it as a means of "attending to the economic side of altering practice circumstances", while **Doctor D** saw that "this is the economic and business side of running a practice. Succession planning requires the most efficient use of each dollar earned."

The youngest of the GPs, **Doctor A,** on the other hand saw it as a vehicle "to look at where you are at and why, to see what you really want to do and what of that is realistic and achievable". **Doctor C's** planning was aimed at "looking to the future so as to improve or to ensure the ongoing stability in your practice, and work out how to work at a pace more suited to this time of life". **Doctor E** took a more global view, seeing succession planning as allowing "the doctor to become aware of some of the issues and factors involved in moving on, including the practice, practice building, staff, community and hospital."

Alterations required as the plan was implemented

Although the intent of each plan was unique, each of the GPs found during implementation that to some degree their plans needed fine tuning. Their experience of making alterations to their respective plans was as follows:

Doctor A: Needed to shift the focus of her plan to gain a different balance between work and personal time because she married, considered further whether she wished to have children, and she also found that she wanted to plan for a long break for the first time in her career.

Doctor B: Successfully moved premises but struck unexpected resistance from one group of allied health workers invited to enter a team relationship in

that premises. Since then, new Medicare item numbers have fostered the teamwork approach.

Doctor C: Found it was not tenable to cease VMO work while continuing surgery consultations, because of the disruption this caused to the care of his clients. Doctor C also wanted to more fully utilise his IT capabilities, for which he needed to be located in a multiple GP practice. He therefore concluded that to implement his plan to reduce his hours, he would need to leave both the town and solo practice. His planning appeared to cause a chain reaction in the town that resulted in plans and commitments to build a single, central medical facility for all the GPs in town, as well as other health care workers.

Doctor D: Unexpectedly struck significant health problems which disrupted implementation. He also found it would take longer and be more complicated than anticipated to sell his practices despite their being both viable and profitable.

Doctor E: Was in the pre-implementation phase at the time of interview in 2007. However, shortly after he completed his plan in 2004 he unexpectedly found that he needed to move into different premises which required significant upgrading. He is expecting it will take another three years to clear the resultant debt, by which time he expects to be ready to implement his plan to work toward retirement.

Barriers encountered and how they were overcome

None of the GPs encountered barriers that they were unable to resolve, but where there were difficulties, they arose in relation to their medical and health service colleagues.

For example, **Doctor A** found that there were and continue to be "huge barriers for people working part time in general practice", since their colleagues see them as not being a "real" GP. She also met resistance within her profession when she chose not to take part in the after-hours roster. Similarly, she found that when a GP takes a significant role in medical education their colleagues do not regard them as "real" doctors. This GP overcame the problems by discussing them at staff meetings and negotiating arrangements that suited her practice needs while covering her existing patient load.

Doctor B was puzzled to find medical specialists in his town initially viewed him as a business threat, but this subsided as he established his new practice. There were no significant problems from other GPs and allied health workers invited to join the venture he had established.

Doctor D found difficulties in attracting a buyer for his practices and replacement GPs and it was unclear at the time of interview how this would be resolved. Given that this barrier and associated delays is typical of rural and remote practice in NSW, this doctor's experience suggests this situation needs careful factoring into succession planning and management.

Experience of when GPs should prepare a succession plan

Given the diversity of the succession plans and their implementation, the GPs' advice about when to prepare a succession plan varied from person to person, but the minimum period was considered to be two years in advance of the planned change.

Doctor C found that at least 2 years lead time was required because it took around 12 months to organise clients and colleagues around the new arrangements that had been negotiated. Given that it took a year before he becoming part of the RDN pilot project to formulate his initial plans, he found the planning and implementation process took 3 years in total. **Doctor E** agreed with this timing, while **Doctor B** believed a period of 3 to 5 years was required, particularly if retirement was being considered.

Although as part of the RDN pilot process **Doctor A** had made and then partially implemented a succession plan, she was of the opinion that a rural GP would need to make a succession plan at around age 40 when they may first begin to consider retirement. In contrast, **Doctor D** believed that a succession plan should be made the moment a GP commenced practice after their initial training period, since he considered this planning to be the business-centred component of the practice - the point being that a GP in private practice is well advised to structure the practice for viability so as to maximise the chances of moving on should the need arise.

Role of and impact on the family

Each GPs' family played different roles in the respective practices. For example, the life partners of **doctors B, C and D** were also their practice manager, whereas the partners of the other two played no direct part in the practice. Consequently the role each life partner played in the planning process, and the impact that implementation had on each of them also varied.

In addition, the children of each of the GPs were at different life stages during the planning and implementation processes. For example, at the time of evaluation, **Doctor A** was yet to have children, **doctors C** and **D** had adult children living independently, while **Doctors B** and **E** each had one dependent child completing their tertiary studies. In addition, **Doctor D** had one adult child working in his practices.

In common all five doctors noted the importance of family in the planning process.

Doctor A had discussed her plans with her husband, but also her broader family (for example, her mother). At the time of evaluation there had been little impact on her life partner, but she expected that implementing her plan would bring benefits to him in the next five years, especially if they chose to have children, or she otherwise decreased her working hours.

Doctors B and E each had one dependent child that they expected would complete their studies in the next five years or so. They both found planning had little impact on their children, particularly those who were already independent. Doctor B believed the main family impact of succession management was that "I am more relaxed in the new practice situation". He noted that while his life partner was supportive of the change process, she had her own career and interests to attend to. By contrast, Doctor E's life partner was more directly affected by the succession planning process since she is manager of the practice.

On the other hand, **Doctor C**, had no children at home but a life partner who was also the practice manager. For him the family played a vital support role. “Often there are long suffering children, wives and partners who traditionally haven’t had much of a say in how your life is going to be organized. Their wisdom was great. The children said it was time to stop working every second night.” As full time practice manager, Doctor C’s life partner was significantly affected by the couple’s agreed plan to move towns (meaning she would need to find work in the new location and would no longer be practice manager for Doctor C) but welcomed the change and was looking forward to living and working in the new location.

The life partner of **Doctor D** similarly was his practice manager, and an additional family member worked in the practices. These two family members had been an integral part of the planning process, although implementation was not far enough advanced at the time of interview to have a significant impact on them.

Communication with other GPs in the town

The need to communicate plans to other GPs in their respective towns depended on the changes each of the participants planned to make. For example, **Doctor B** found no need to communicate his plans to move surgery to any other GPs, but his next proposed move into a group practice has required considerable consultation with GPs in the other practice involved. Similarly, at the time of planning, **Doctor E** had no other GP in town with which to discuss these things, while **Doctor D’s** plan to sell his practices would have no real impact on his colleagues.

On the other hand, **Doctor A** discussed her plans with a close friend in her practice plus another two partners. Although she noted attitudinal resistance to part time general practice both within and outside her own practice, her discussions were productive so that the practice accommodated her decrease in hours by employing a part time registrar, and organising a job share arrangement.

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Doctor C, who was planning to withdraw from VMO and after hours services, as well as reduce his surgery hours, had the most unexpected outcome from consulting with his colleagues. Despite the extra load his plans would place on the other doctors in town, he found them “very supportive” even when he found he needed to withdraw from the town altogether. His advising the medical services in town that he intended to leave acted as the impetus for stakeholders to initiate discussions on establishing a long-term strategy for providing sustainable medical services in the town, with the result that plans for a new health centre (possibly an integrated primary health and community care service) have been formulated.

Method of informing the community, and its outcome

Two of the GPs have not yet needed to inform their community of their plans to change practice arrangements. The other three each chose to inform their clients one by one as they presented for a consultation.

Doctor A had a varied but satisfactory response when she told her regular clients how and why her surgery hours would be limited. Some clients who found this arrangement unsuitable transferred to another GP, while others decided they would wait for a vacancy so that she remains fully booked well in advance. Still others have been educated to use her services interchangeably with those of the other female doctor with whom she shares the full time practice load as well as the client records.

When **Doctor B** moved surgeries, he placed flyers in his original surgery and notices in the local newspaper, with the rest being done by the town's "rumour mill". Given that the new surgery was within 5 kilometres distance of the original one, he found that most clients transferred with him.

Doctor C, who was the only GP to move to a new town, believed that the response from his clients (who he informed in consultations and through placing a notice in his surgery), was one of the greatest benefits of succession planning. He valued the resultant lack of angst in his practice and amongst his clients. While many had been upset – even in tears - to hear he was leaving, his clients had generally wished him well and were planning to transfer to new services in the town. In the broader medical community he found a generalised willingness to help and to offer useful suggestions. The level of support and collaboration surprised him, helping him formulate what turned out to be a far superior outcome than he could ever have guessed.

In developing the succession planning tool, RDN noted a widespread fear among GPs that the moment they advised their clients that their hours would change or that they would cease service at a nominated future date, their clients would "desert the sinking ship". This was an important concern since if it came to pass, doctors wishing to put their practice on the market, or wishing to continue the final weeks of service on an even economic keel, would find themselves with diminishing returns and a less valuable business to offer any purchaser.

The experience of the GPs who piloted the succession planning tool and then implemented their plans in full or part, found this fear was unfounded. Even the GP who closed his surgery and moved towns found that generally his clients were loyal almost to the end.

Method of informing staff

Again, this varied from GP to GP depending on their circumstances and their plans, but each of the GPs was satisfied with the outcomes. Those GPs who needed to inform staff of their plans chose a direct method, usually through one to one conversations or through staff meetings.

Doctor A made her plans known in staff meetings, with staff taking her change in hours in their stride. She was surprised to find, however, that she needed to help staff provide what she saw as a more suitable explanation to her clients, so that they replaced "She only works two days a week" with "She only works HERE two days a week". It also took time to train staff to channel

her clients in her absence to the on duty doctors rather than emailing or telephoning her for advice.

Because he wanted to transfer his existing staff from his original practice to his new location nearby, **Doctor B** found no problems informing staff of his planned move. It has been more challenging to advise them very early of his current plans to enter a new group practice, since his staff may need to apply for the jobs that will become available at the proposed new centre.

Doctor C kept his staff (other than his practice manager wife) informed of his plans during staff meetings, and discussed what the future might be for them. By the time he left the town, his staff had moved on and his practice manager wife was seeking alternative employment in their new town.

Both **Doctor D** and **Doctor E** have had little or no need to inform staff of their plans – Doctor D because his full time staff are family who have known of his plans all along, and Doctor E because he has no firm change plans yet. Doctor E has noted that his one full time non-family staff member may not wish to work beyond three or four years, which is about when he expects to implement his succession plan.

Professional or personal support/ advice sought during planning and implementation

Each of the GPs had both a personal and professional support network they utilised in formulating their plans. While the amount of advice each of the GPs sought from either source varied, they all sought some level of advice from trusted colleagues as well as professionals from business disciplines.

Doctor A, for example, spoke with trusted and experienced colleagues in a variety of her work places to find out how they "do things". She also discussed her plans with her mother and her husband. **Doctor B** on the other hand, consulted his wife, a specialist friend with legal experience, his lawyer and his accountant, as well as other doctors.

Doctor C scanned the succession planning checklist to select individuals he believed were useful and relevant to his situation. These included his accountant, the Area Health Service, local colleagues, his wife and his children. By contrast, **Doctor D** already had accounting and legal advice at hand, reflecting his belief that the most important people for guidance throughout a medical career are proficient, up-to-date lawyers and accountants.

Doctor E found that his experience working with doctors' organisations stood him in good stead when considering his plan, with the only other professional input coming from his accountant.

Strategies put in place to ensure continuation of service

Although each of the GPs set out to achieve different outcomes with their succession plans, each aimed to ensure that medical services for their clients were not reduced.

To do so, **Doctor A**

- ensured other doctors were on duty on the days when she was not working at the surgery
- entered a job sharing arrangement with another female GP
- trained staff (including the practice nurse) in the procedures to be used when one of her clients presented in her absence
- instructed her clients about the availability of doctors (who can view the shared patient record) when she is not at the surgery.

Because **Doctor B** provided the same level of medical service at a different location, (but increased the level of allied health service available in this location) there was no real break in service. He found that some clients chose not to transfer with him but they were replaced with new patients.

Doctor C had far more difficulty since he was planning to cease his service in a town where he had been practising for 32 years, 16 of them in solo practice. The fact that he began discussions with relevant stakeholders very early meant that the town was able to consider and put into action a plan to build an integrated primary health care service which would bring all the GPs as well as allied health and community health staff into one building.

Doctor D found his plans were built on ensuring continuity of service, since he planned to sell his practices, including the comprehensive client and business records (paper based and then computerised) he has maintained all along.

Although **Doctor E** had yet to implement his retirement plan, his preference will be to replace himself with one or more doctors. To that end he has listed the practice on the RDN website with a view (like Doctor D) to attracting an Overseas Trained Doctor since he considers they are “the only hope for the next half century” in terms of having an interest in purchasing a rural general practice. Like Doctor D, he has maintained his patient records, gained accreditation for the practice and situated the practice in the centre of his town so as to maximise the chances of the service continuing with a replacement doctor.

Perceptions of the most valuable aspects of implementing a succession plan

Each of the GPs found it constructive to reserve some time for planning, and they each gained different insights in the process. They included the following:

Doctor A was looking forward to continuing with her plan, finding it valuable to think about her future and add further direction to her existing five year plan.

Doctor B found the planning process challenging because it “made me think about things a fair bit”, but having vocalised and written the plan, it was much easier to see the plan into fruition. “Thinking, speaking and writing helped

make the plan real". He also found it invigorating to formulate a change plan rather than continuing with "more of the same", which he had found personally and professionally stultifying. Even though he was "at the end of my tether when I wrote the original plan", the process gave him renewed energy to successfully bring about rewarding change.

Doctor C was surprised to find the main benefit derived from "being honest with everyone" about his plan and realising "I didn't have to go and hide any more, I could talk to other people about it" and most importantly, "it was going to be OK".

Through his planning process, **Doctor D** realised he'd lost touch with certain aspects of his profession. For example, he had not supervised registrars for about 20 years, and yet the most likely purchaser of one or both of his practices would be a registrar who he had trained. In response to this realisation, he investigated what would be required to become a supervisor again, and how he may be able to find an Overseas Trained Doctor with an interest in working in and/or purchasing his practices.

Doctor E came to a renewed awareness about his future plans and a realisation that plans needed to be drawn up as an exercise rather than haphazardly put together. He also found that he understood first hand how that planning exercise could be completed.

Perception of the most challenging aspect of the process

Generally the GPs found their own limitations or perceptions presented the most challenging aspects of the succession planning process. For example, while **Doctor A** found the actual process of planning relatively straightforward, setting aside the time to do it was difficult. By contrast, **Doctor B's** main challenge lay in the psychology of change, that is, the confronting process of making the decision to change. **Doctor E** found himself in a similar situation where he felt overwhelmed by the notion of getting started, and of thinking about finishing his working life. He also found demanding the process of committing his plan to paper.

Doctor C found his own reservation about bringing outsiders into his confidence a most difficult aspect of the process. "I found it very difficult calling my colleagues in for a meeting and saying 'fellas I'm thinking of leaving in 12 months'. That cost me, but they were fine with it".

Doctor D's greatest difficulty has been in finding a buyer for his practices, a challenge that is the more significant because it is shared by many rural GPs.

Commitment required to complete a plan ie; time, costs.

Each of the GPs found that succession planning consumed less of their time than they expected, and to a person they felt the outcome more than warranted the effort. However, completing their plan required focus and commitment, which could be difficult in the face of the competing demands on their time. They each needed to dedicate time to the planning process.

Although **Doctor A** forwent some income while she formulated her plan, she didn't think of it in those terms at the time or at any time afterwards. There were no additional economic costs, since she found no need to pay for professional input.

As a solo GP, **Doctor B** enjoyed putting aside planning time because he was then able to meet relevant people over, say, breakfast to discuss various aspects of his plan. The costs of implementing his vision were daunting since he committed to a large building with an equally large lease figure before he had sourced other health professionals to share the building and its rental costs.

Doctor C found he needed to devote a few weekends and a few nights to the planning process, and that he had "endless discussion with my partner". He also paid for advice from his accountant.

With most of his succession planning information already at hand, **Doctor D** found he needed very little additional planning time. When it came to implementation, however, he found a lot of work associated with finding a buyer, especially among Overseas Trained Doctors.

Doctor E's planning required "a day or two" of concerted effort, with some smaller tasks subsequently being completed from time to time because the planning could not be done in a single sitting. However, purchase and refurbishment of his new surgery took so much time that his practice manager spouse took on the full time role of development manager.

Recommendations or advice for other rural GPs who may be considering planning for their succession

Each of the GPs has become a proponent for the succession planning process among rural GPs, and recommended that sufficient time be allowed for both planning and implementation. Their words of advice to their colleagues were:

Doctor A: "It is important to plan your succession and do it early in your general practice career, and regularly review and modify it. The earlier you do it, the more likely you are going to make changes that will benefit you medically and personally."

Doctor B: "Don't be too daunted, we are reasonably conservative people we doctors, we don't like starting something that fails, we have a lot of pride in ourselves. Also don't be afraid of being team leader in a multidisciplinary team."

Doctor C: "My recommendations to my colleagues, particularly in country areas is to consider the succession process early, at least two years before you are thinking of making any change, even if it is only minor change in how you want to work. This process can be immensely valuable in helping your peace of mind, in helping your confidence about the future and in carrying through your plans. One of the most valuable things I've ever done in my

extra curricular activities was giving just a little bit of extra space to the succession planning process, it opens up all sorts of vistas and possibilities that you can hardly believe when you first start out. Just take the time to do it, work through it and the rewards will be there."

Doctor D: "Succession planning begins when your working life begins. There are stages in the succession plan throughout your career."

Doctor E: "Succession planning is something that should be done, you need to rise to the discipline of it. Probably if you are around 50 years of age is about the time it should be implemented and have a 10 year plan. It seems many rural doctors start to go off at that stage to other pastures. It may also be better timing when the last child is in Year 10 or if the GP intends to go with kids to a city school and then maybe come back when the kids are off their hands."

Conclusion

Without further input or encouragement from RDN, all five rural GPs who had trialled the succession planning tool in late 2004 had by early 2007 implemented all or part of their plans. While none of them had retired or otherwise removed themselves from the working arena, one had moved town, another had moved practices, a third had changed the balance of surgery and teaching work, another had bought and refurbished a surgery building, and the fifth had begun the lengthy process of finding a buyer for his surgeries.

While the small numbers preclude state-wide conclusions, the results suggest that once a motivated rural GP takes the time (in itself a problem in this professional group) to create a succession plan, s/he will at the appropriate juncture use the plan to effect as smooth a succession into new circumstances as s/he can manage.

While some aspects of their work circumstances were identical (for example, the GPs were all in traditional private practice arrangements) each plan and each implementation process was unique, validating the succession planning tool as adequately flexible for the broad array of personalities, styles, aims and aspirations of this professional group. This evaluation exercise acted as a reminder to expect every succession plan and its implementation process to be different, without expecting any differences in the chances of success.

One factor driving RDN to develop a succession planning tool was rural GPs' oft repeated fear of becoming trapped in a town where any changes they make to their work circumstances impacts directly and negatively on the townsfolk with whom they have a close personal and professional relationship, sometimes developed over decades. For example, leaving a town can mean a location already pressed for GP services plummets to an even more desperate situation. This has not been helped by the changing business environment where rural general practices are less likely than in the past to be considered desirable businesses to purchase, and the competition for GPs is severe. Superimposed on these fears are the horror stories of rural

GPs who see no other solution but to close their surgery one Friday afternoon, without warning to community or staff, with the intention of never opening again in that town.

It was rewarding, then, to find that one GP enjoyed spectacular success in implementing his succession plan. This GP, who had cared for several generations in a country town over a 30 year period – indeed had delivered the babies of those babies he had brought into the world early in his career – was, with little angst for the wellbeing of his clients, able to close his practice and move to another town knowing that by implementing his succession plan, and letting the town know of his intention to leave, he had caused far sighted plans to be put into place to ensure medical services continued in the town. The relief this GP expressed to be able to take his clients' good wishes with him, and be free of concern over how they would manage in his absence, was profound.

Although each plan and each implementation was different, the GPs shared common themes. These were:

- An awareness that the succession planning process needs to be initiated at least two years in advance of any changes a rural GP wants to make.
- Experience indicating the succession planning process requires far less time than imagined, and little or no expense in terms of professional advice.
- Experience of other GPs in the town cooperating as best they can to allow the GP to change their circumstances.
- Experience of clients remaining "loyal" to the end rather than "deserting the sinking ship" in great numbers the moment they are informed their GP plans to move from the town or reduce their consultation hours.
- Experience of the succession implementation process generating good will in rural towns.
- The need for the GP to draw support as required from both personal and professional networks during planning and implementation.
- Unique personal challenges emerging from the planning and implementation processes.
- The need to remain flexible in order to modify plans as required by emerging circumstances.

Overall, the evaluation process indicated that even though insufficient time had elapsed for all the GPs to have fully implemented their succession plan, the succession planning tool had served each of them well.

APPENDIX 1

Interview - A GP's experience of Planning for Succession

1. **What has happened with your succession plan since you made it a couple of years ago. For example, have you gone on to implement all or part of it, or changed your plans?**

(looking for implemented/not implemented divide to determine line of questioning to follow). If has not implemented any – why is that? (Been busy, changed directions, not time to implement yet?)

2. **What stage are you up to in implementing your plan?**

(information on where in the process they are placed, and what has changed in terms of practice arrangements since they made their plan. Check if it is related to the planning process or divorced from it).

3. **For you, what is the purpose of succession planning and management?**

(their definition of succession planning and what it means to a person who has made and implemented a plan)

4. **As you implemented your plan, did you find you needed to alter what you had planned? If so, how and why?**

(information about how implementation highlights things in the original plan that won't work or could be done better.)

5. **Have there been any barriers or opposition you have encountered? If so, what are they? How did you overcome them?**

(difficulties to look out for, ways of working around problems, tips for others implementing a plan.)

6. **Going on your own experience, how far in advance of a planned significant change in working arrangements do you think a GP should make and begin implementing their succession plan?**

(some of the finer details to do with timing, and recommendations they would make from their own process.)

7. **What is/was the role of your family in making and implementing your plan?**

(whether family considerations or support have been important in the succession management process, and what role family issues have played in helping or hindering the process)

8. **Briefly describe what the impact of implementing your plan has been on your spouse and children.**

(Arrangements made for work/school/moving from town. Other considerations.)

9. **Have you talked to the other GPs in town about your plans, and if you have, what happened?**

(Any challenges in doing this? Any unexpected or surprising responses? Any responses to do with competition?)

10. **How did you go about informing the general community of your plans and what was the response?**

(Is there a way of doing this that worked for them? Was it hard? How did they respond? Did you find yourself with no patients left since they'd all bailed ship?)

11. **And what about your staff, how did you or will you inform them?**

(What was the response? Have you/they been able to make alternate employment arrangements?)

12. **What professional or personal support/ advice did you seek while implementing your Plan?**

(who are the key partners in this process?)

13. **Have you put strategies in place to ensure your patients continue to access good quality health care after you change what you are doing? What are those strategies?**

(yes/no, and then what kind of strategies. Have they worked?)

14. **What were the most valuable aspects of implementing your succession plan?**

(What key learning did you make? What key differences has the plan made? Any surprises? Any barriers?)

15. **What was the most difficult or confronting aspect of the process?**

(what made it hard?)

16. **Give an outline of your commitment ie; time, costs.**

What time, costs, and other commitment did you have to give to the Planning process

17. **Do you have some recommendations or advice for other rural GPs who may be considering planning for their succession?**

(Why succession planning is/isn't a useful thing, tips, tricks, good stories)