2024

AHS Family Physicians with Special Skills Workforce Forecast

FORECAST & REPORT

2023-24

July 2024

ALBERTA HEALTH SERVICES

Table of Contents

Executive Summary

Family Medicine with Special Skills

The 2023-24 Family Medicine Physicians with special skills Forecast anticipates that the Albertan FM Physicians' workforce could increase by 340[1] FTE over the next 10 years to maintain the same level of service. That translates to a compound annual net new FTE increase of 2.9%.

During this same span, over 390 FTE will need to be replaced due to physicians leaving the workforce. The 10-year family medicine physician with special skills FTE total recruitment need (new and replacement) is estimated at 730.

Compared to the previous year (2022-23):

1. The opening roster (i.e. existing physicians) FTE has decreased by 2.3%.
2. The net new recruitment forecast has decreased by nearly 22%[2].
3. The Replacement Recruitment rate dropped by 14%[3]. And Separation (i.e. retirement) rate has decreased by 5.5%.
4. 2.9% increase in the rate of physicians leaving Alberta compared to coming in.

Family Medicine is not a homogenous group. Although, this report is developed by Alberta Health Services (AHS), the forecast is comprised of all family medicine/general practitioner physicians in Alberta (including those working exclusively within private community clinics).

In total, the forecast includes FTE projections for 12 different groups of family medicine physicians with various subspecialty training and experience (see page 3 for detail). These physician groups may more commonly practice within AHS facilities.

FM Care of Elderly/Seniors Care[4] projects to have the largest 10-year FTE growth rate (70%) this year followed by FM Addiction Medicine and FM Cancer Care (45%). To maintain the same level of service and to be able to respond to the province's aging population and growing needs in the next 10 years, the province may need to recruit 165 new FTE Family Physicians with Seniors Care skills. FM Care of the Elderly/Seniors Care has projected to be the highest growth need area within Family Medicine since AHS began family medicine workforce forecasting in 2024.

The majority of Family Medicine Physicians with special skills may need to replace almost 40% of their current workforce throughout the next 10 years due to workforce attrition (which includes retirement and migration out of province, among other factors).

The recruitment rate (total recruitment to opening FTE) is over 70% on average.

FM Care of the Elderly/Seniors Care and FM Addiction Medicine may need to recruit 110% and 100% of the size of their current roster respectively. This includes both net new and replacement recruitment.

[1] Including Planning Variables
[2] Due to effects of Covid Pandemic on the past two years of health data.
[3] Due to adjusting the Gender Shift ratio this year.
[4] FM Care of Elderly/Senior Care has been on top of our list for the past few years.

Family Medicine

This is the third year that Family Medicine forecasting matches our forecasting methodology for College of Family Physicians of Canada (CFPC) specialties. The Family Medicine categories are broken down into the following 12 sub-categories and the abbreviations used for this report:

Family Medicine Sub-Categories	**FM Sub-Categories abbreviation**
FM Addiction Medicine	FM Addiction
FM Anesthesia	FM Anes
FM Cancer Care	FM Cancer
FM Care of the Elderly/Seniors Care	FM Elderly
FM Child and Adolescent Health	FM C&A
FM Enhanced Surgical Skills	FM Surg
FM Hospital Medicine	FM Hospital
FM Mental Health	FM Mental
FM Obstetrical Surgical Skills/ Maternal & Newborn Care	FM Obstetrics
FM Palliative Care	FM Palliative
FM Respiratory Medicine	FM Resp
FM Sport and Exercise Medicine	FM Sport

Family Medicine physicians will be sorted into the above categories based on a combination of AHS Appointment information and Alberta College of Family Physicians (ACFP) licensing information.

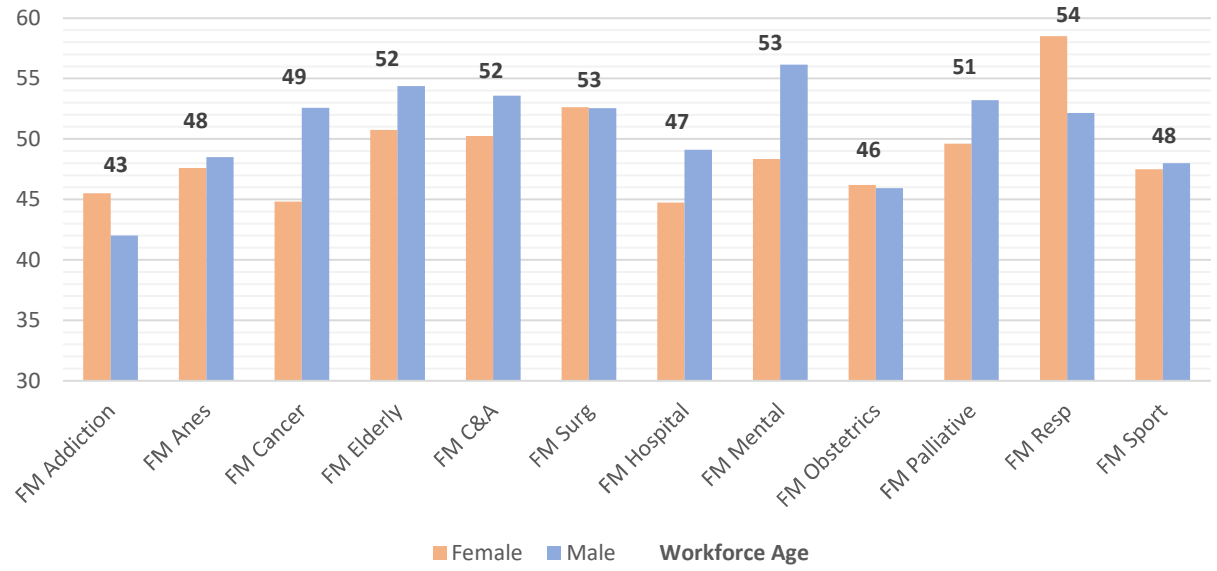
The report includes all Family Medicine physicians with special skills in Alberta, including both with and without an AHS Appointment.

Demographics[5]

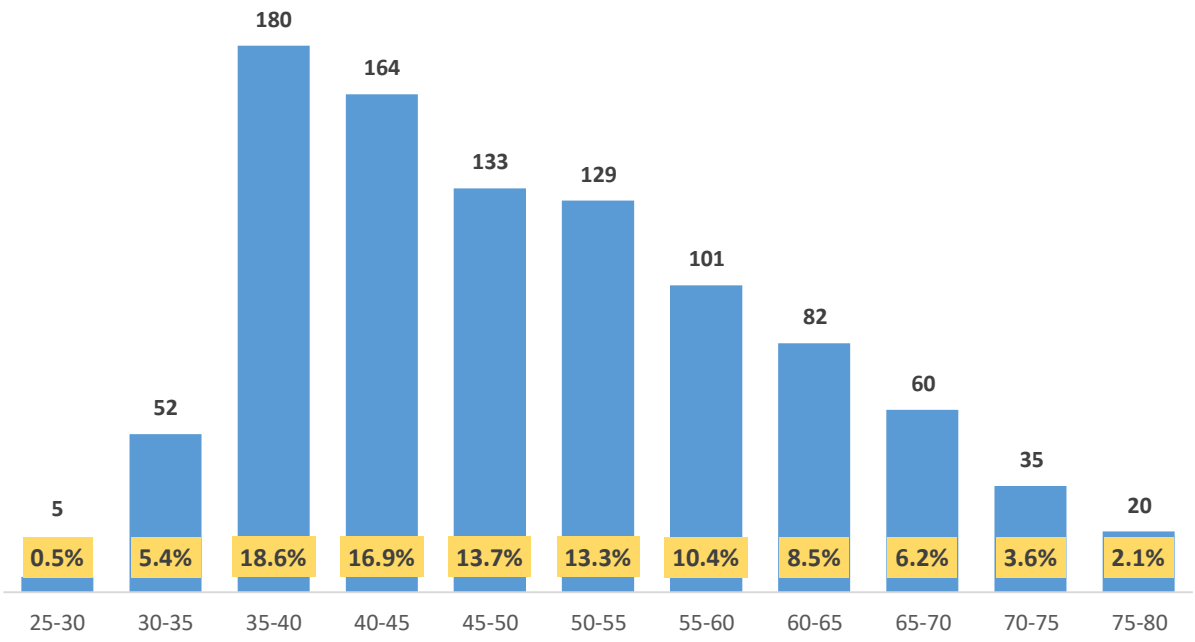
Over 50% (436) of the Family Physicians with Special Skills' workforce are Female. The average age of active physicians is 50 years old. The Headcount to FTE (total) ratio is almost 90%.

Categories	Female FTE	Female HC	Male FTE	Male HC	Total FTE	Total HC	Female FTE/HC	Male FTE/HC	Workforce FTE/HC	Female %	Female Age	Male Age	Workforce Age
FM Addiction Medicine	1.6	2	3.0	5	4.6	7	80.0%	60.0%	65.7%	28.6%	46	42	43
FM Anesthesia	22.4	29	44.7	58	67.1	87	77.2%	77.1%	77.1%	33.3%	48	49	48
FM Cancer Care	10.5	11	12.0	12	22.5	23	95.5%	100.0%	97.8%	47.8%	45	53	49
FM Care of the Elderly/Seniors Care	99.0	116	97.7	109	196.7	225	85.4%	89.6%	87.4%	51.6%	51	54	52
FM Child and Adolescent Health	12.0	12	14.0	14	26.0	26	100.0%	100.0%	100.0%	46.2%	50	54	52
FM Enhanced Surgical Skills	21.5	22	37.0	37	58.5	59	97.7%	100.0%	99.2%	37.3%	53	53	53
FM Hospital Medicine	82.4	100	98.0	120	180.4	220	82.4%	81.7%	82.0%	45.5%	45	49	47
FM Mental Health	27.0	27	44.5	46	71.5	73	100.0%	96.7%	97.9%	37.0%	48	56	53
FM Obstetrical Surgical Skills/ Maternal & Newborn Care	131.0	139	47.0	49	178.0	188	94.3%	95.9%	94.7%	73.9%	46	46	46
FM Palliative Care	24.7	31	12.7	18	37.4	49	79.6%	70.6%	76.3%	63.3%	50	53	51
FM Respiratory Medicine	2.0	2	7.0	7	9.0	9	100.0%	100.0%	100.0%	22.2%	59	52	54
FM Sport and Exercise Medicine	2.0	2	2.0	2	4.0	4	100.0%	100.0%	100.0%	50.0%	48	48	48
Total	**436.1**	**493**	**419.6**	**477**	**855.7**	**970**	**88.5%**	**88.0%**	**88.2%**	**50.8%**	**48**	**52**	**50**

The following graphs present the Family Medicine subspecialty workforce age distribution. Almost 12% of the workforce are 65 years or older; and over 31% are 55 and older.



[5] Physicians older than 80 years of age have been removed from the demographic report.


Age Group Ratio
180
164
133
129
101
82
60
52
35
20
5
0.5%
5.4%
18.6%
16.9%
13.7%
13.3%
10.4%
8.5%
6.2%
3.6%
2.1%
25-30
30-35
35-40
40-45
45-50
50-55
55-60
60-65
65-70
70-75
75-80

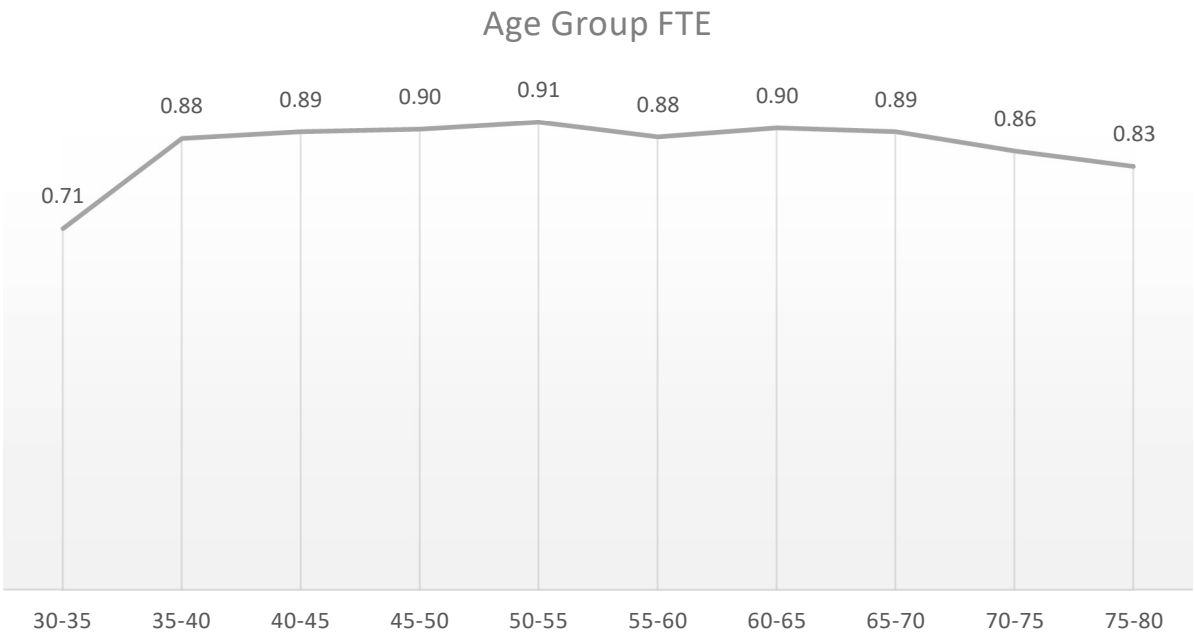

Age Group FTE
0.71
0.88
0.89
0.90
0.91
0.88
0.90
0.89
0.86
0.83
30-35
35-40
40-45
45-50
50-55
55-60
60-65
65-70
70-75
75-80

Table 1: 10 Year New FTE and Total Growth Rate (%)[6]

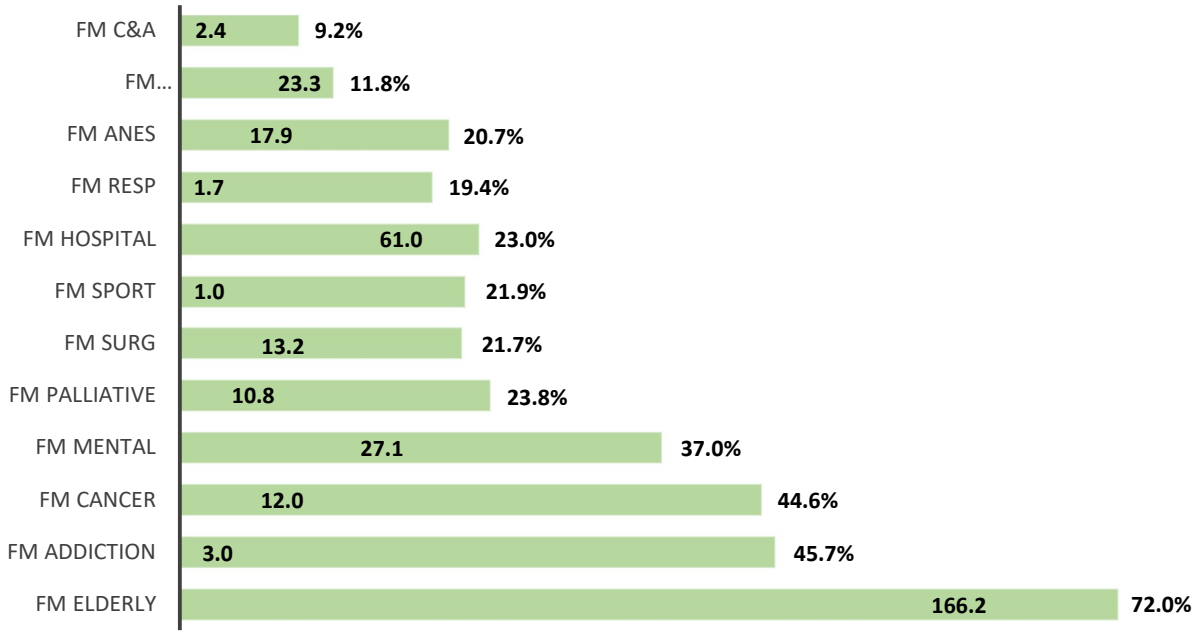
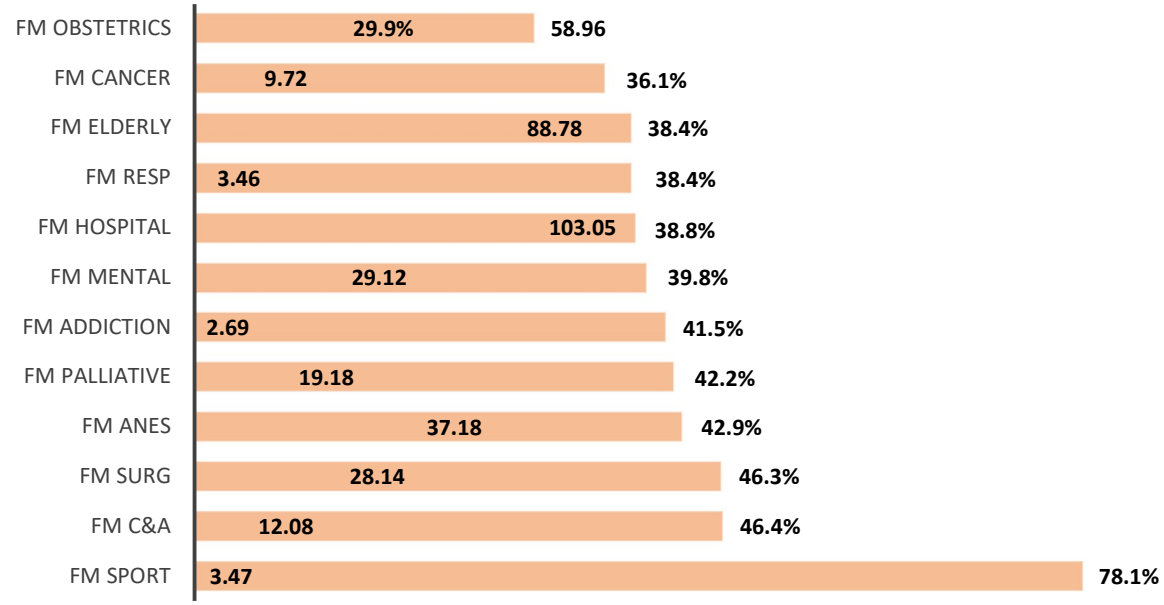


Table 2: 10 Year Replacement FTE and Total Replacement Rate (%)[7]



[6] The numbers on the pillars refer to the anticipated net new FTE Need and the percentages above the pillars indicate the net new to current workforce FTE ratio.

[7] The numbers on the pillars refer to the anticipated replacement FTE and the percentages above the pillars indicate the replacement to current workforce FTE ratio.

Table 3: 10 Year Recruitment and Total Recruitment Rate (%)[8]

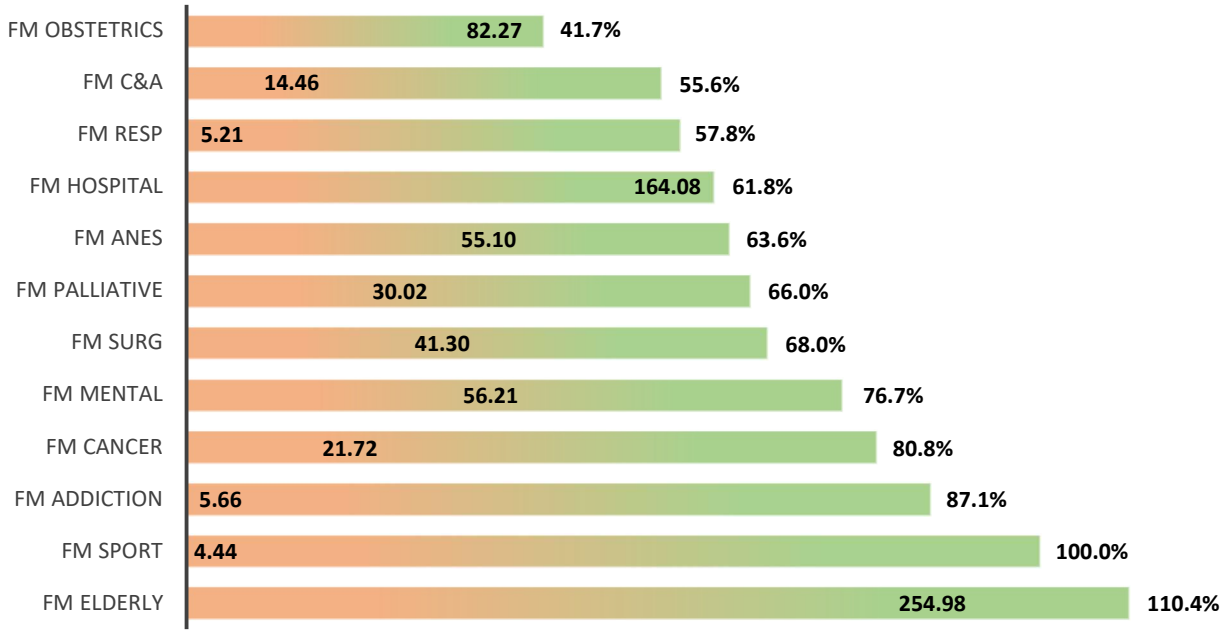
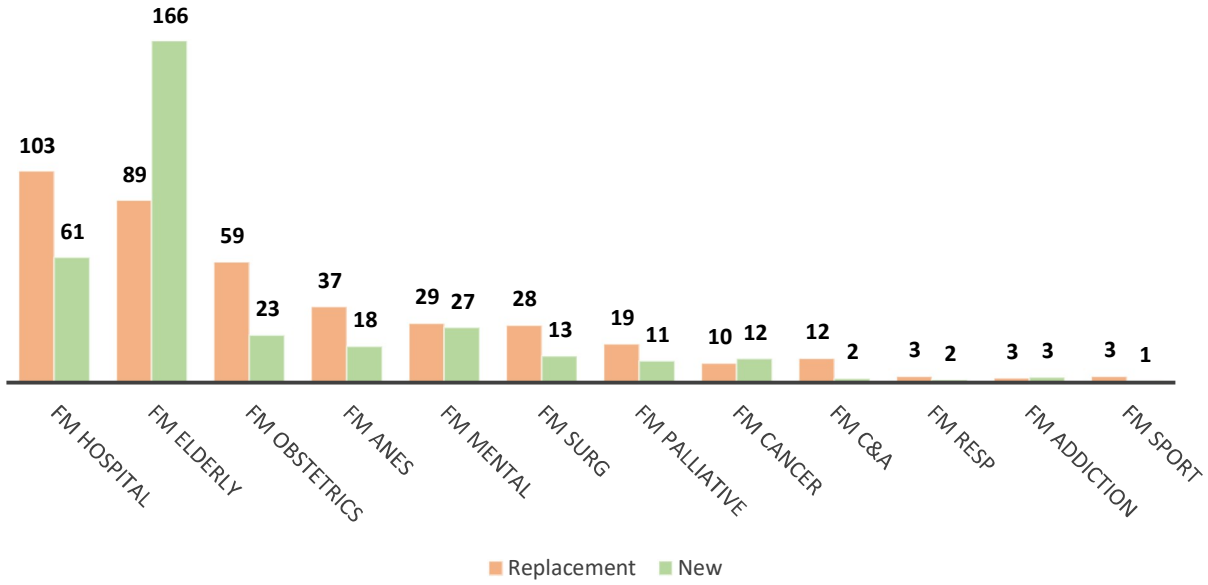


Table 4: New vs Replacement[9]

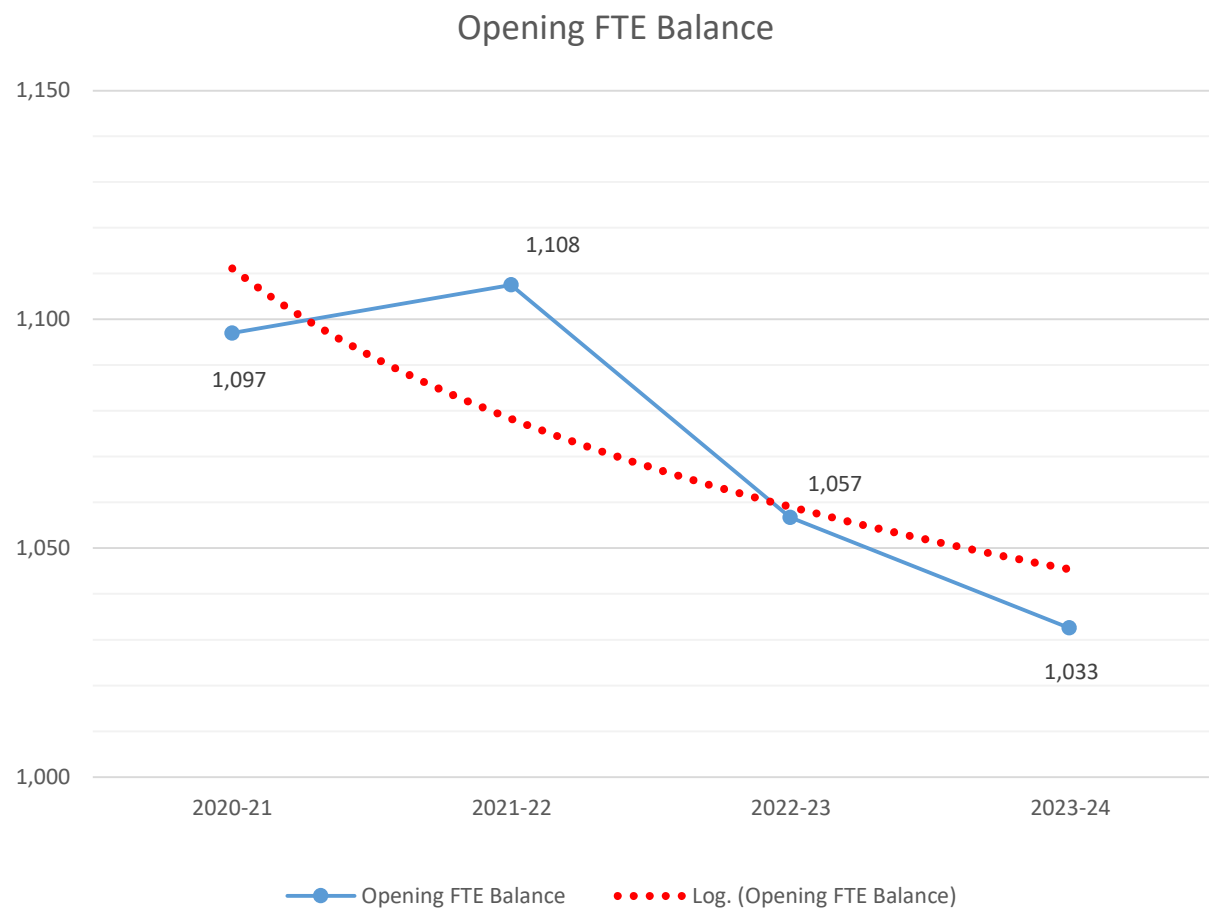


[8] The numbers on the pillars refer to the total anticipated recruitment FTE and the percentages above the pillars indicate the 10 years recruitment to the current workforce FTE ratio.
[9] The specialties are sorted by descending order based on the current workforce FTE size.

4 Years Trend Analysis *(Special Skills)*

1) Opening Roster FTE

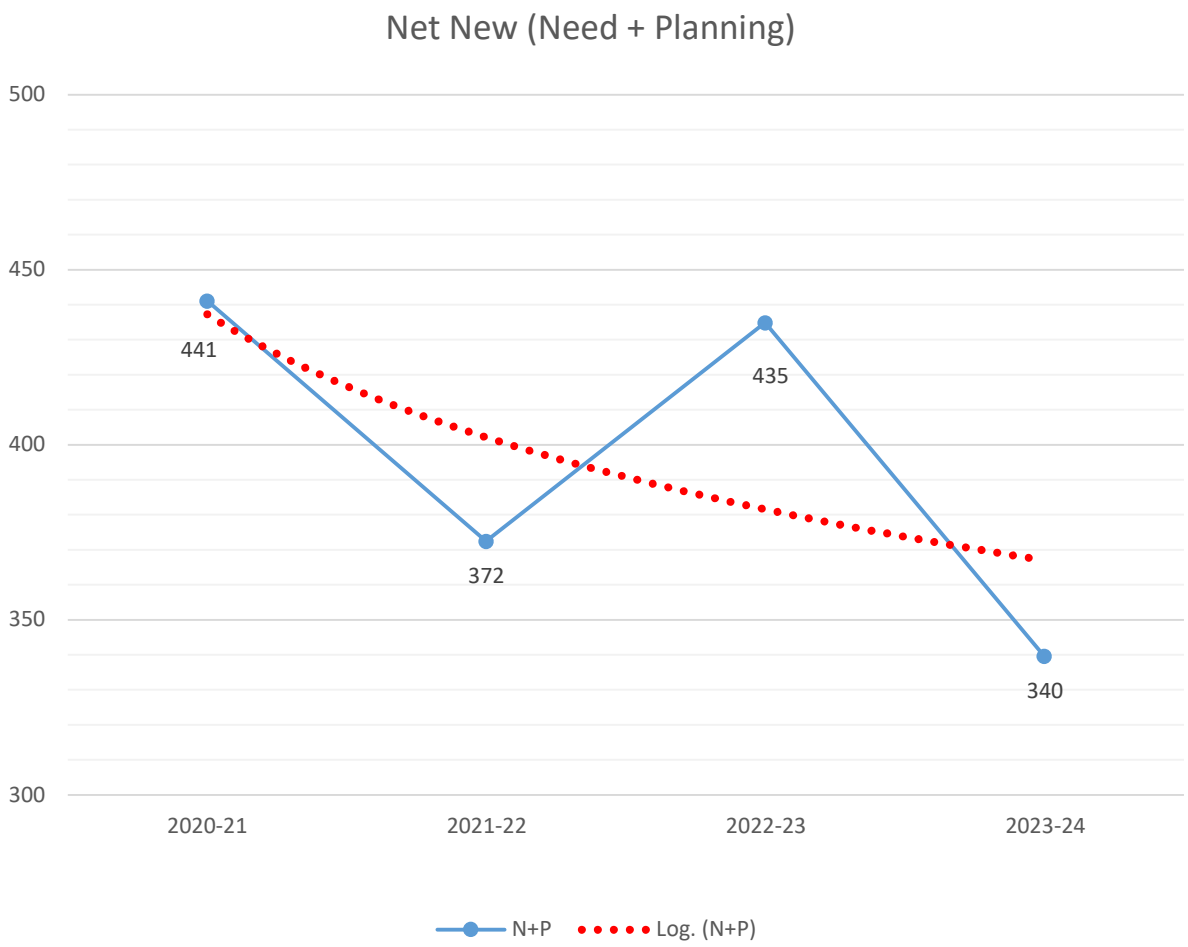
The opening roster in this year's forecast (2023-24) shows 2.3% decline compared to last year[10]. Over the span of 4 years, physician FTE growth has decreased by almost 6%. No change in opening FTE is anticipated for the next year, based on the overall trend.



[10] The drop in opening FTE from 2022-23 comparing to its prior year was due to removing inactive physicians from the application.

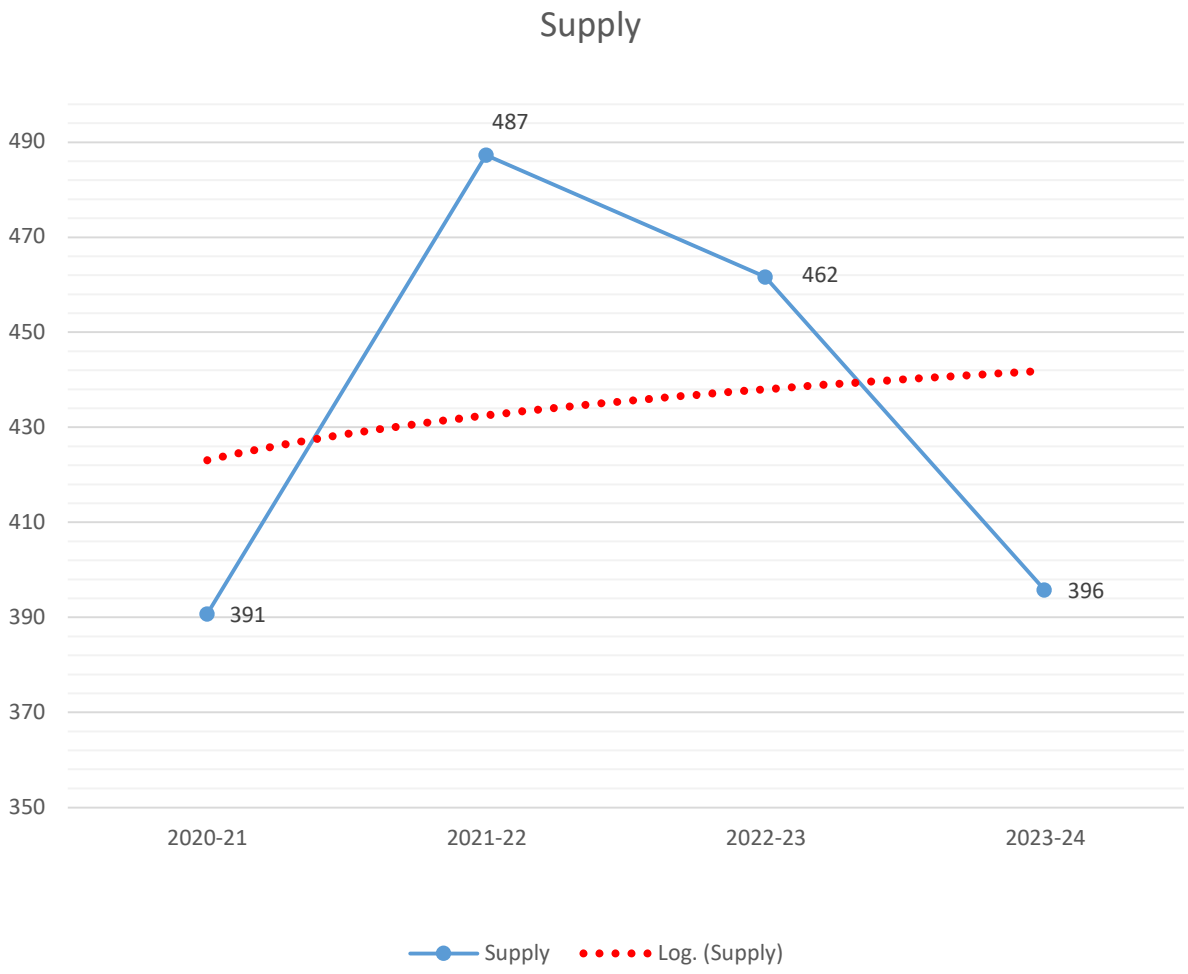
2) Net New (Forecasted New Need + Planning Variables)

The forecasted need FTE (calculated by the application) and the planning variables' FTE (adjustment applied by the medical leaders) combined form the total Net New FTEs. The Net New FTE has decreased by almost 22% compared to last year. The 4 years trend line (dotted line) anticipates approximately 4.4% growth in Net New FTE for the next 10 years.



3) Anticipated Replacement Recruitment (Supply)

This year's forecast indicates almost 400 FTEs are needed throughout the next 10 years to fill in replacement positions. On average, 25 FTEs exit (retire) from the workforce per year; it follows a steady declining trend. In addition to the separation, the replacement section includes Gender Shift and NIPM/RFA.

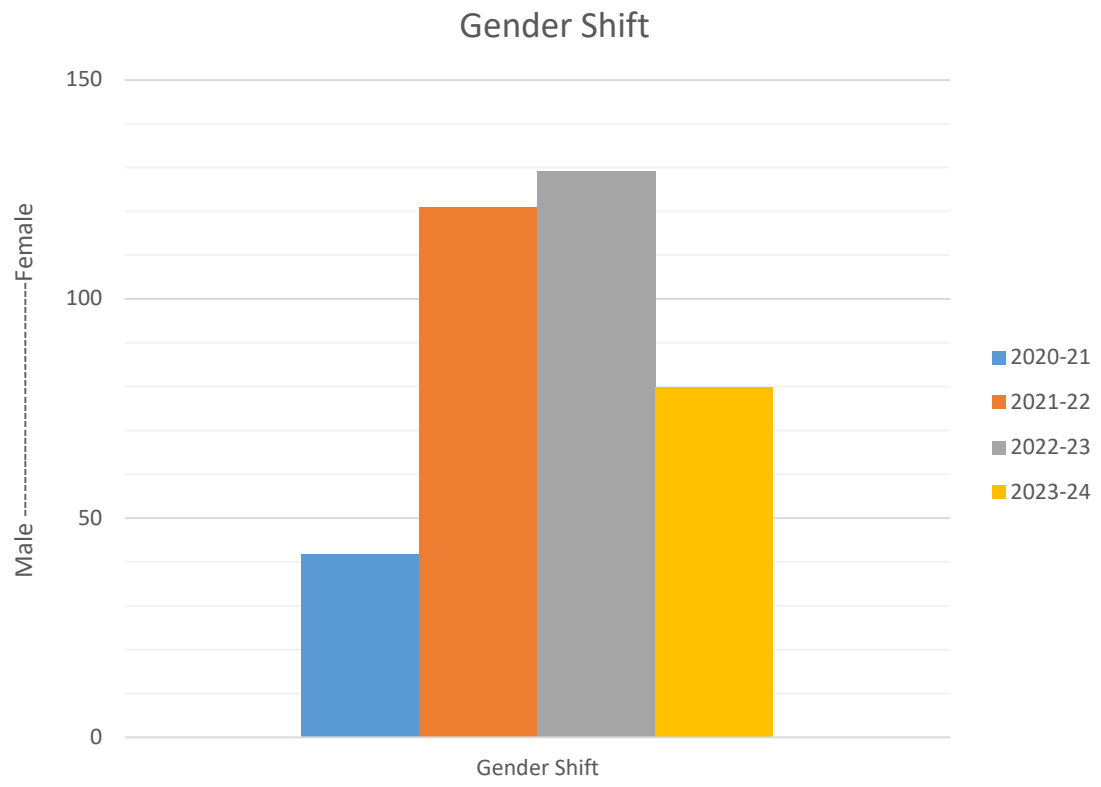


3.1) Gender Shift

Gender Shift measures the relative workload productivity by specific age, as expressed by Full Time Equivalency (FTE) values, between male and female physicians to adjust the forecast FTE according to the current and predicted male/female mix data shows different FTEs worked at different life stages.

The methodology uses Alberta Health billing data to estimate volume of clinical work by age and gender. AHS is aware that billing data does not translate perfectly to time spent with patients and Gender Shift is not intended to suggest that male and female physicians work more or less than each other.

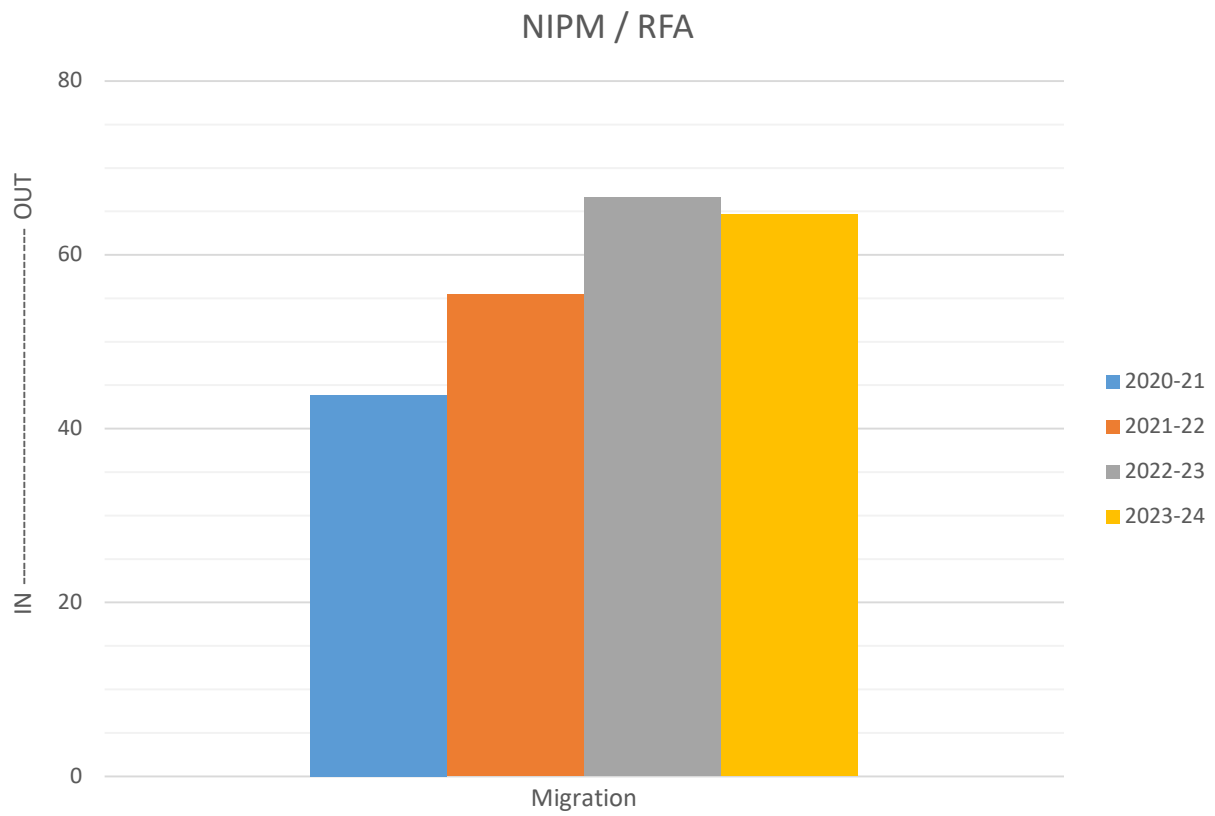
However, increasing numbers of female physicians could indicate a need for more locum coverage at certain stages of life (e.g. maternity leaves). Therefore, negative numbers suggest the male workforce FTE is increasing and the positive values indicate the increase in female workforce FTE. We have reviewed new studies and explored new data points on FTE related to Gender Shift this year. The female to male replacement trend is still upward but the replacement value has decreased as a result.



3.2) NIPM / RFA

Rate of physicians' Net Inter-Provincial Migration (NIPM) and rate of Return From Abroad (RFA). To adjust future supply for the predicted number of physicians who will migrate into and out of province within Canada (NIPM) and for the predicted number of physicians who will migrate into the province from out of country and migrate out of country from within the province (RFA).

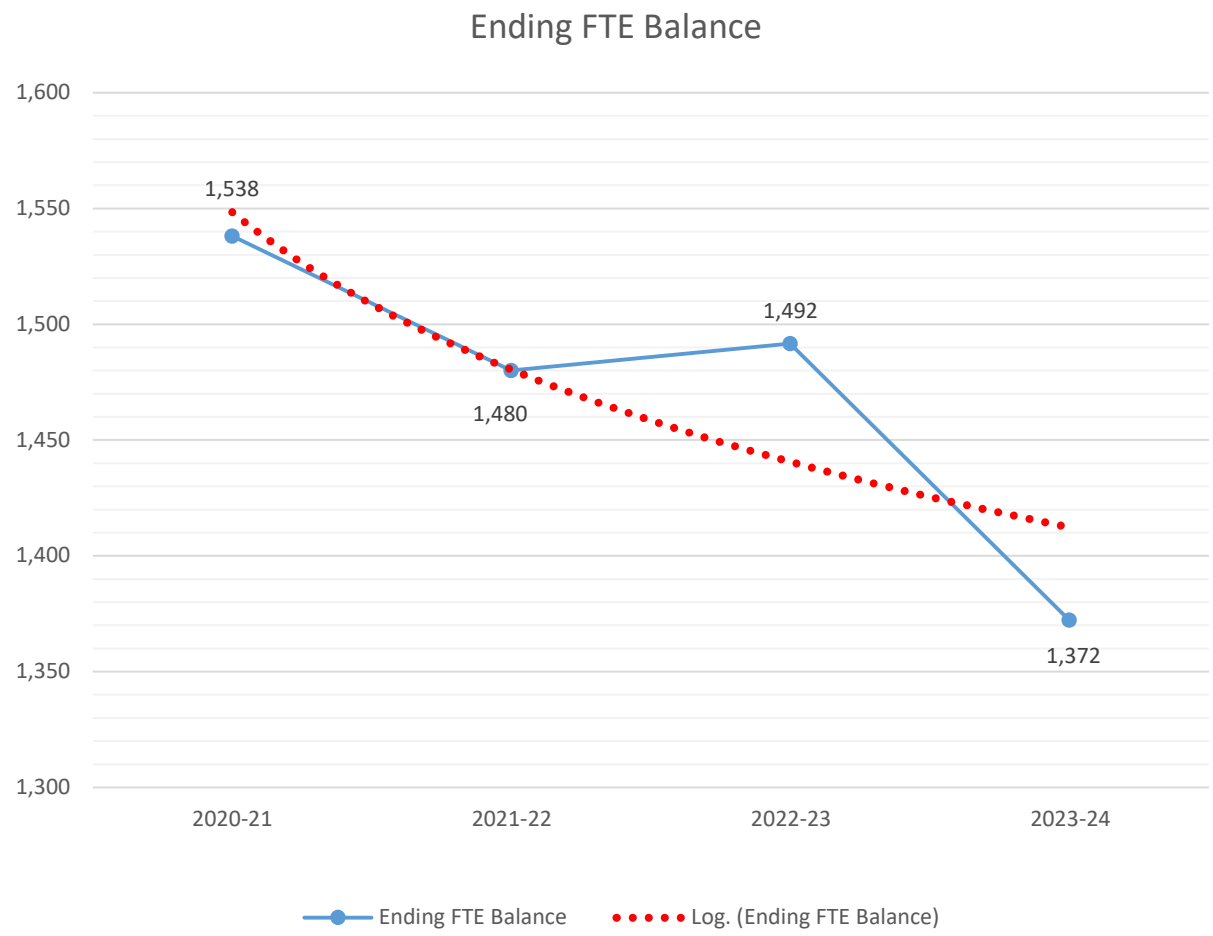
Our 4-year workforce data trend shows a negative migrating trade off[11]. Basically, more and more workforces are leaving our province to other provinces or countries. It means we need 65 more FTE to neutralize the effect of migrations out of Province and out of country throughout the next 10 years.



[11] This year's numbers are not following the general upward trend comparing to previous years. This change will be revisited next year to reassess the trend line if needed.

4) Ending FTE Balance

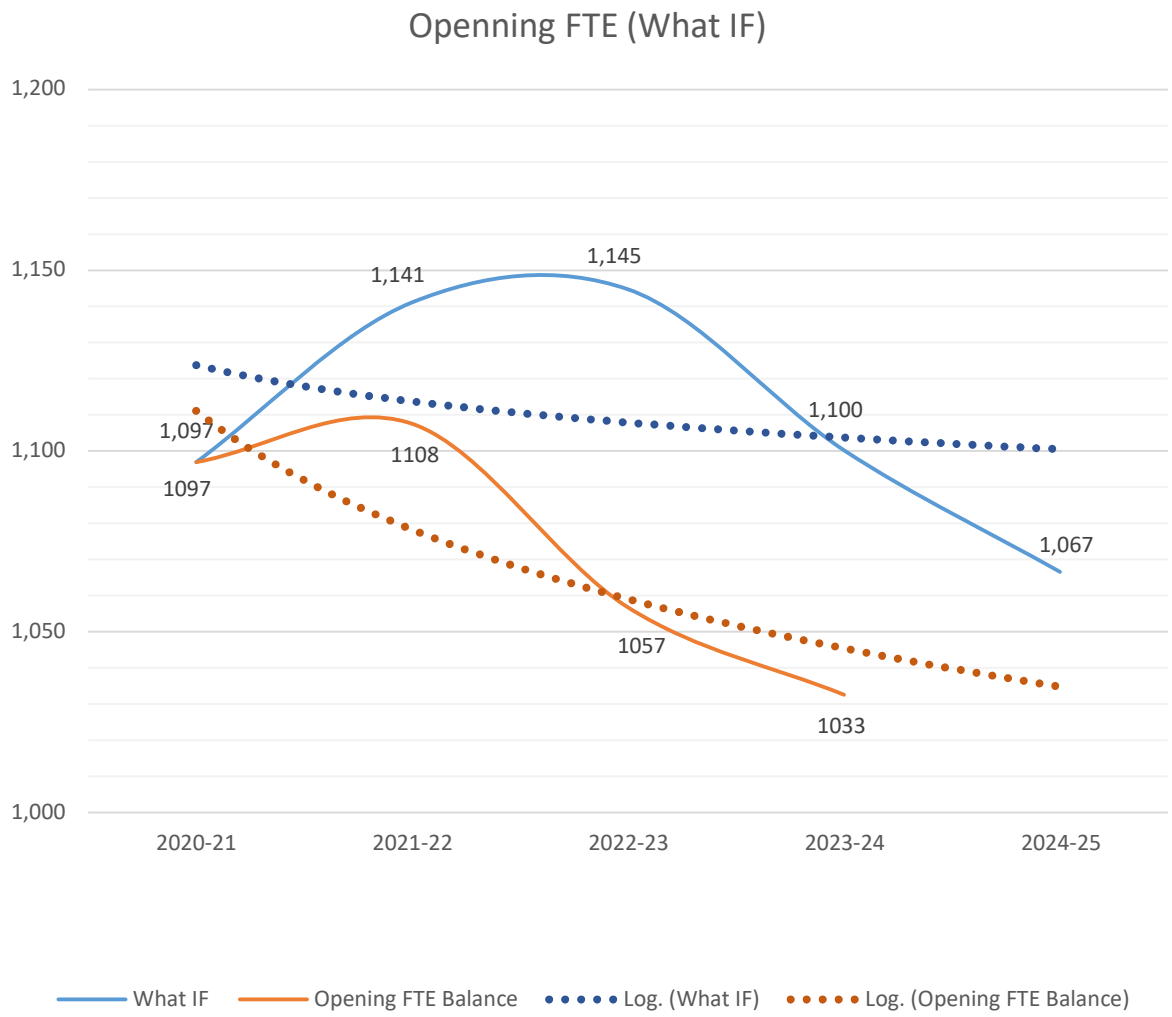
The ending (10 years) FTE balance is equal to current roster FTEs plus the Net New FTEs considering all replacement positions been filled. Following the 4 years trend line, it is expected to see am FTE growth of almost 1.5% next year.



5) What IF

In the following graph, the actual opening FTE is compared with the forecasted opening FTE balance (the forecasted ending FTE of the prior year). The "What If" value is the actual opening FTE of the prior year plus the anticipated net new need of the same year, which represents the next year's anticipated opening FTE. For example, this year's opening FTE is 1,033 (orange solid line). Based on the last year (2022-23) net new need forecast (43) and its opening FTE (1,057) the opening FTE for this year should have been 1,100 (blue solid line) IF all suggested net new FTEs were recruited successfully.

The gap between the Opening FTE trend line (dotted orange) and the What If trend line (dotted blue) measures the recruitment success. The wider the gap the lesser the success in recruitment. The data trend points to a consistent gap year-over-year, between our anticipated net new need and our actual annual FTE growth (~65 FTE). The "What If" forecast suggests almost 30 FTE (2.9%) deficit for next year (2024-25).

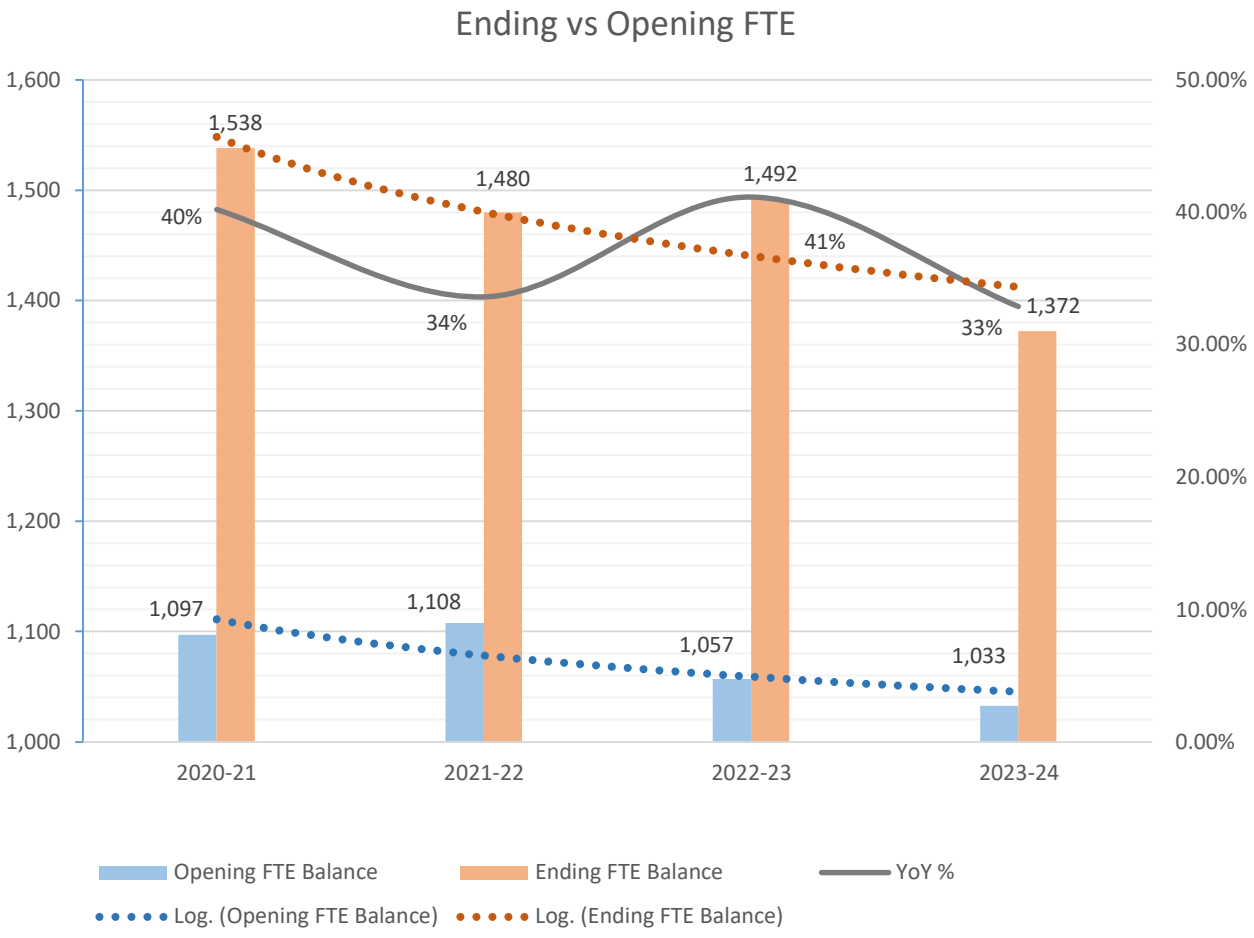


6) Planning vs Need FTE

The following graph shows the magnitude of the adjustment (by Zones) to the forecasted FTE, so called Planning Variables.

This graph in addition to earlier (6. What If) graph provides better insight on workforce forecasting and recruitment planning. By applying proper planning variables, we can present a more realistic workforce forecast to fit our recruitment planning reality.

Having said that, in coming year(s) planning variables will play a major role to adjust the net new forecast due to irregularity in health data that has caused by the COVID-19 pandemic[12], change in medical practices and emerging new technologies.



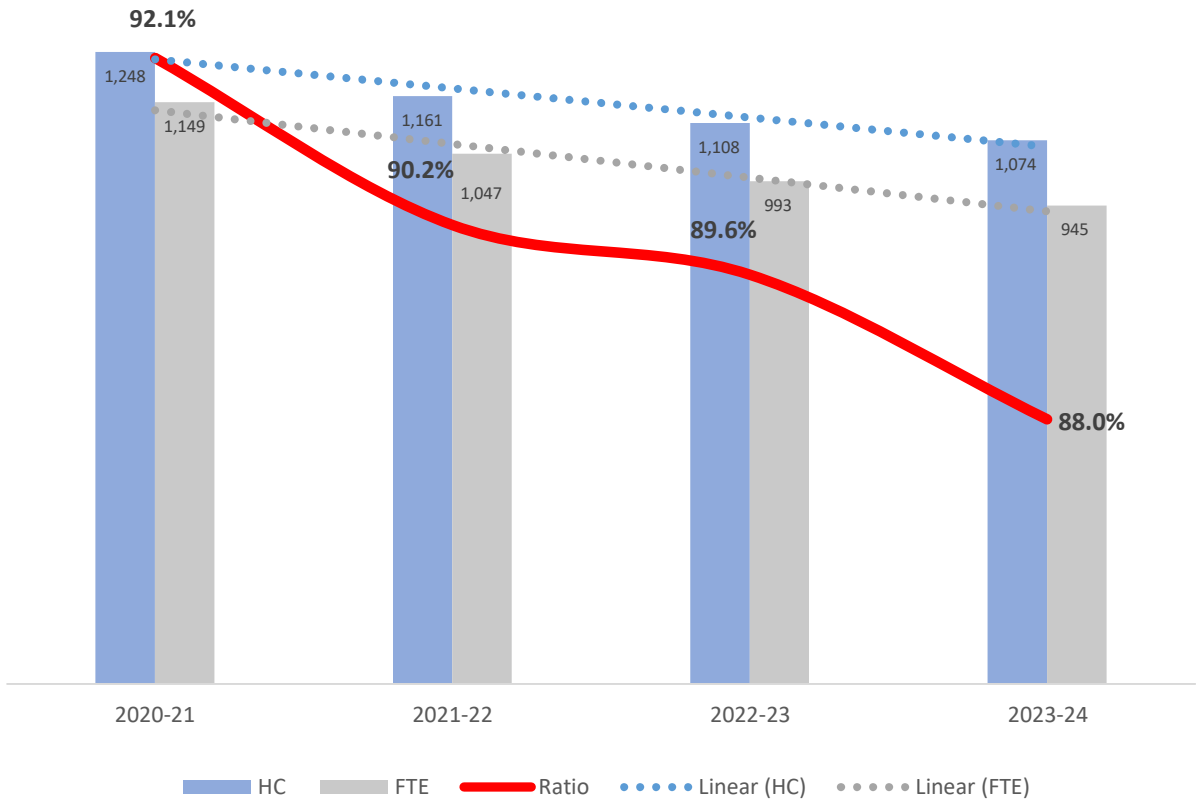
[12] The growth in planning variables application in this year is mainly applied to compensate for the lower net new forecast due to irregular health data trend since COVID 19 Pandemic.

FTE vs Headcount (Specialists)

The workforce forecasting methodology focuses on physicians FTE (full-time equivalent) rather than headcount[13]. Studying the relationship between headcount and FTE can contribute to better recruitment planning.

Four years of specialist workforce data has been used to explore the evolving relationship between the physician workforce headcount and FTE.

1. The recent year data shows slow decline in FTE/HC ratio. Current value is 88%. The solid blue line represents this change throughout the past four years.
2. The dotted blue line shows the headcount declining trend.
3. The FTE throughout the past 4 years show a slowly downward trend. (dotted grey line).
4. Since year 2020, our Family Medicine with Special Skills workforce headcount has decreased by almost 14% while the FTE has decreased by less than 18%.



[13] In occasions that FTE is not available the headcount (FTE=1) will be applied.

Policy Opportunities – for 2024 Physician Workforce Forecast

This year's forecast presents AHS and our healthcare partners with a number of important considerations regarding our future physician workforce. The forecast itself is simply one tool available to leaders and policy makers to reference when thinking about the sustainability of our healthcare system and being able to rise to meet future need. However, when the projections can be connected with recruitment planning, current and anticipated workforce supply shortages, physician education planning, and known future legislation, it allows AHS to recommend some policy and project opportunities to assist Alberta in meeting our future workforce needs and/or changing the course of the forecast by exploring alternative options beyond the recruitment of more physicians.

In 2022-23, AHS has identified several policies / project opportunities to help Alberta address our future physician workforce need:

1) **Re-establishment of the Physician Resources Planning Advisory Committee (PRPAC) or equivalent**
   The PRPAC and its sub committees, disbanded in 2018, provided an opportunity for stakeholders from AH, AHS, AMA, CPSA, the two Faculties of Medicine, RhPAP, other organizations, and physician and public members to convene as a group to share data, identify levers for physician supply/recruitment/retention, and implement action plans. AHS will work with AH re-establish this forum, or establish a new forum with similar principles.

2) **Senior's Care**
   AHS first began reporting family medicine clinical FTE in 2021. In addition to community/primary care, Family Medicine was further broken down into 12 subgroups. The group showing the most potential for net new growth over the next 10 years is FM – Care of the Elderly / Senior's Care. The forecast anticipates that our current workforce of 245 FTE could be expected to grow to 421 FTE over the next 10-years; an increase of 72%. The forecast is being driven by population growth by age group (baby boomers approaching age cohort requiring more care and more complex forms of care) and current trends in access to senior's care services. AHS will develop a plan to share these projections with relevant internal and external groups to validate the forecast (does it align with current perception of the workforce and potential growth?) and, if needed, develop an action plan to address the potential high future need of family medicine physicians with specific care of the elderly certification or training before Alberta is faced with a deficit that would impact patient access to care.

3) **Post Graduate Medical Education (PGME) Distribution and Volume**
   AHS has engaged with AH and the two Alberta Medical Schools to demonstrate how our workforce forecasts in anesthesiology and non-urban family medicine compare with the known supply of new resident physicians graduating into practice in Alberta. Although, not all physician recruits in Alberta are strictly University of Alberta or University of Calgary graduates, these samples may still help us identify together which groups may be in oversupply (i.e. the residents

may not find full time work upon graduation) and which groups we do not have enough of (i.e. we have a large deficit or have identified a large future recruitment need). Discussions are already underway to increase the available annual residency training spots within anesthesia residency programs and post-graduate re-entry programs, as well as residency training spots in rural family medicine programs. AHS will continue to work with PGME program stakeholders to continuously monitor and deliberate over PGME training seats in ways that allow the physician education system to be flexible and responsive to Alberta's physician needs.

4) Cancer Care Support

Family physicians play an important role in the care of cancer patients in Alberta.
In addition to seeing cancer patients in their primary care clinics, some family physicians provide support in urban cancer center clinics, supervise chemotherapy in community cancer centers, run supportive care survivorship clinics and help care for cancer inpatients admitted to hospital. In the past, few general practitioners in oncology have had formal training. Recently, several third-year enhanced skills programs and continuing medical education programs in cancer care for family physicians have been developed at several other Canadian universities.

Patient access to cancer treatments over the past few years is increasing and given Alberta's population demographics, it is expected the need for these services will continue to rise. Alberta will need to ensure that these training programs can provide a steady supply of family medicine physicians with these enhanced skills.

Appendix A - Data Collection

Physician Workforce Planning (PWP) Software Application

The PWP software application gathers and reports data related to specialist physicians in terms of clinical FTE. This software application produces standardized forecasts reflective of population health needs, service delivery requirements, planning and resource allocation, and AHS business plans.

The PWP application scope includes:

All specialist physicians licensed for independent practice by the CPSA, including physicians working in AHS facilities and Community-based physicians

Canadian College of Family Physicians (Emergency Medicine) Certificates: family medicine physicians with an AHS primary appointment in Emergency Medicine and family medicine physicians with an AHS supplementary appointment in emergency medicine who work in a facility with 24 hours on-site emergency coverage.

The PWP application does not include short-term locums (physicians who are working in the same role/position less than 12 months), physicians with limited practice licenses (e.g., limited to clinical assisting or surgical assisting), or dentists/oral & maxillofacial surgeons/podiatrists.

There are three essential parts to the PWP forecast: Needs Assessment, Replacement Assessment, and Planning Adjustment.

Needs Assessment

Four methodologies are used to forecast specialist need.

The software application provides a data driven, statistical platform to review the 77 Royal College of Physicians and Surgeons of Canada (RCPSC) specialties regarding their current commitment in clinical FTE by Zone and at a provincial level, over a period of 10 years.

In the PWP software application, each RCPSC specialty has one forecast method set as default.

Method A uses CIHI HPG data (based on AH physician Fee-For-Service (FFS) claims data, AHS emergency and ambulatory care visits, aggregated from the previous 10 years) and is directly assignable to the RCPSC specialty in question.

Where there is insufficient claims data, **Method B** uses proxy HPGs as these specialties cannot be linked to HPGs directly.

For specialties using **Method C**, little FFS and hospital admission data is available, and specialties cannot be linked to another specialty as a proxy. Therefore, forecast need is linked to incidence of HPGs related to the specialty's work across the total weighted population.

In contrast with methodologies A, B and C, **Method D** is used where the requirement for physician services is driven by coverage requirements rather than volume of services, such as a certain number of hours of coverage in a defined facility and service. Typically, this methodology is used only for critical care medicine and emergency medicine.

Replacement Assessment

The Replacement Assessment uses current physician workforce demographic data (e.g. age), information on new Canadian graduates, gender shifts, rate net inter-provincial

migrations, and retirement/departures from practice to further refine the forecast.

Planning Adjustment

The PWP software application cannot anticipate adjustments in required net new clinical FTE due to development of new policies, AHS service delivery changes, facility development, and/or changes in medical practice (e.g. new technologies, philosophical changes in medicine). Zone Clinical Department Heads and Section Chiefs review their current roster, review the Needs and Replacement Assessments, and may still choose to adjust the forecast further to account for some of the factors mentioned above.

Appendix B - Methodology

Specialist physician workforce forecasting is supported by a software application, providing data-driven forecasts organized by Royal College of Physicians and Surgeons of Canada (RCPSC) specialties for specialist physicians and Canadian College of Family Physician (CCFP) categories of added competency or special interest for Family Medicine physicians. The plan's projections are based on data regarding population health needs, changes in population growth, current workforce, retirements and departures, gender mix, service delivery methods and volumes, and AHS and Covenant Health facility capacity. It also considers anticipated replacement of physicians, based on current medical school and residency program enrollment across Canada. Together, these inputs shape a forecast of workforce need.

Additional data has been collected from the College of Physicians & Surgeons of Alberta (CPSA), the Alberta Health Interactive Health Data Application (IHDA), the AHS Appointment & Privileging application, and the Canadian Institute for Health Information (CIHI).

Integrated Workforce Planning Approach

AHS develops multiple strategic workforce plans that help lead the organization from where it is now to where it would like to be. Many of these plans - including this one - are provider specific. As such, the target audiences, plan-to-plan, are different. This may lead to differences in plan format and content.

It is important to remember that the report is a conversation tool/guide to stimulate thinking around trends and developments in medicine service delivery models, capital planning and population health services need in Alberta. The report is intended to help AHS make decisions on service planning and influence choices made by Alberta Health, Faculties of Medicine, medical students, residents, etc.

The numbers provided in this forecast are not a target; but rather a projection. The forecast is not a recruitment plan and AHS is not committed to realizing the projections found within this report. These (recruitment) increases could not be supported without operational and infrastructure changes. New models of care may drive physician FTE changes, but it could also drive more Nurse Practitioners, Physician Assistants, and other care providers to support and extend our existing physician workforce. Future physician

forecasts will need to continue to account for changes in medical practice, resource requirements, and new policies. However, Medical Affairs works closely with Health Professions Strategy & Practice, Human Resources, and other stakeholders to develop an integrated approach to workforce planning. Many sources of data used within the Physician Forecast are also used as part of Midwifery or Nurse Practitioner workforce planning. Plans are also shared and discussed between groups and can often influence each other. From a physician forecasting perspective, we must keep aware of policy changes or new service delivery models that will have direct or indirect effects on physician planning.

AHS's four organizational goals provide a common ground for alignment across all AHS workforce plans:

1. Improve patients' and families' experiences.
2. Improve patient and population health outcomes.
3. Improve the experience and safety of our people.
4. Improve financial health and value for money.

Planning Variables
(Forecast Adjustment)

Planning variables need to be applied to account for physician net new need associated with program expansion, incoming policy changes, infrastructure developments, etc., as these are areas the application cannot predict.

Before adding extra FTE as a planning variable, the followings should be considered:

a. The current forecasted need: making sure the "extra" need is above and beyond the forecasted net new FTE need by the tool.
b. Feasibility; considering the economic climate.
c. Applying the most accurate timeframe/fiscal year to produce accurate yearly forecast reports.

Although, planning variables are mostly used to address extra "need", there are situations where negative planning variables could be applied.

a. There could be change in policies that can affect workforce expansion negatively. They need to be addressed through planning variables.
b. When there is no planned recruitment in (near) future, add negative FTE(s) to zero out the specific fiscal year(s) FTE.
c. Since the forecasted need is distributed evenly (linear) throughout a 10-year period, usually it would not align with the zone/department/section's strategic planning. Adding or subtracting planning variable FTEs to each year could better align the forecast with the recruitment plans.

Planning variables can enhance workforce forecasting process and outcome while overestimated or inappropriate ones can damage the creditability of the result

2023-24 vs 2022-23

The COVID-19 pandemic has affected many aspects of our life since March 2020. One of which is the health service delivery methods that have been adapted to mitigate the harsh effects of the disease and to increase and to improve Albertans access to health facilities.

The rapid increase in demand of acute care and decrease or delay of surgical procedures have affected the health data set gathered by CIHI for the year 2020 to 2023. These data sets, compared to previous years, show lower than average patient volumes, physician billings, etc. which affected our forecast anticipated future net new need.

Using the skewed health data due to aforementioned reasons, affected the validity of our 10-year forecast significantly resulting in almost 22% decrease in net new to current roster FTE ratio.

For the past two fiscal years physicians' workforce forecast AHS had decided to replace the 2020-21 HPG data (the most affected health data by COVID-19 Pandemic) with its prior year (2019-20)[14]. This year the real 2020-21 HPG data was used. As a result the we had a slight dip in Net New FTE faced comparing to prior years. Moving forward we will continue the forecasting practice as usual.

[14] Each year's forecast uses the prior year's health data, and so forth. For example, 2023-24 (current fiscal year's PWP forecast) would have used 2022-23 health data. Last PWP forecast (2021-22) was utilizing 2019-20 (before COVID-19 Pandemic) health data.

Appendix C - 10 Year Forecast

SPECIALTY_NAME (RCPSC)	Opening FTE Balance	Result	Gender Shift	NIPM /RFA	Separations	Subtotal	Planning	Replacement Recruitment	Need	10-Year Recruitment	Ending FTE Balance
FM Addiction Medicine	6.50	3.17	1.56	0.41	0.73	2.69	-0.20	2.69	2.97	5.66	9.47
FM Anesthesia	86.70	16.30	12.56	5.43	19.19	37.18	1.63	37.18	17.93	55.10	104.63
FM Cancer Care	26.90	12.01	1.37	1.68	6.66	9.72	0.00	9.72	12.01	21.72	38.91
FM Care of the Elderly / Seniors Care	230.98	166.73	8.42	14.46	65.89	88.78	-0.53	88.78	166.20	254.98	397.18
FM Child and Adolescent Health	26.00	2.38	2.22	1.63	8.23	12.08	0.00	12.08	2.38	14.46	28.38
FM Enhanced Surgical Skills	60.75	13.41	5.80	3.80	18.54	28.14	-0.25	28.14	13.16	41.30	73.91
FM Hospital Medicine	265.54	57.47	29.06	16.62	57.37	103.05	3.56	103.05	61.03	164.08	326.57
FM Mental Health	73.26	27.09	2.22	4.59	22.31	29.12	0.00	29.12	27.09	56.21	100.35
FM Obstetrical Surgical Skills / Maternal & Newborn Care	197.05	20.79	12.11	12.34	34.51	58.96	2.51	58.96	23.30	82.27	220.35
FM Palliative Care	45.48	11.00	2.87	2.85	13.46	19.18	-0.15	19.18	10.85	30.02	56.33
FM Respiratory Medicine	9.00	1.75	-0.02	0.56	2.92	3.46	0.00	3.46	1.75	5.21	10.75
FM Sport and Exercise Medicine	4.44	0.97	1.60	0.28	1.59	3.47	0.00	3.47	0.97	4.44	5.41
Family Practice	**1,032.60**	**333.06**	**79.76**	**64.64**	**251.42**	**395.82**	**6.57**	**395.82**	**339.63**	**735.45**	**1,372.23**