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Where are they now?

The career paths of the Remote Vocational Training Scheme registrars

Background

The Remote Vocational Training Scheme trains doctors in remote communities using distance education and supervision.

Aims

To document the training location, outcomes of training, current location and services provided by program graduates and assess the effectiveness of their training.

Results

Twenty-four doctors graduated from the Remote Vocational Training Scheme program. Registrars provided over 44 years of clinical service in very remote areas during training. Of those working in Australia, 17 out of 21 (81%) still work in rural areas and 20 (95%) gained dual qualification of Fellowship of the Australian College of Rural and Remote Medicine and Fellowship of The Royal Australian College of General Practitioners. Registrars evaluated the program as effective preparation for clinical practice.

Conclusion

The first medical specialist training program in Australia and comparable western countries to use remote supervision achieved its targets of increasing retention of the rural and remote workforce during and after training.

Keywords: vocational education/graduate education; education, medical; rural health services; rural health; education, distance



Australians in rural and remote areas have higher rates of morbidity and mortality and lower access to health care than their urban counterparts. Rural and remote health professionals are required to deliver complex care,^{1,2} but turnover is high.³ Considerable welcome investment is being made to redress this workforce imbalance with initiatives aimed at increasing the number of doctors skilled and willing to work in rural and remote areas postqualification.³⁻⁵

This article highlights the outcomes from an alternative approach: a program designed to train and support doctors already working in isolated or solo practice in rural or remote Australia. Supervised clinical practice is required in all specialist training programs. Postqualification professional development through distance education is well established,⁶ but to our knowledge this is the first medical specialist training program, in Australia and comparable western countries, to use distance supervision throughout training.

The Remote Vocational Training Scheme (RVTS) trains doctors for remote communities, in remote communities. The aim is to support comprehensive high quality service delivery during training and promote retention after training. Without RVTS, isolated doctors would have to leave their communities to complete vocational training. The program offers training toward Fellowship of The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM), and by extension, for vocational recognition as a general practitioner with Medicare Australia.

The Pilot Remote Vocational Training Scheme (PRVTS) was established in 1999 as a joint training initiative of the RACGP and ACRRM with funding from the Australian Government Department of Health and Ageing. In 2006, an independent company, Remote Vocational Training Scheme Ltd, was established to manage the program and deliver training, again with Commonwealth government funding.

Supervisors, experienced in rural or remote medical practice and working in the same geographical region, support registrars remotely. Contact is a minimum of 1 hour per week in the first 6 months, 1 hour per fortnight in the second 6 months, and 1 hour per month thereafter using telephone, text, fax, email or internet videoconferencing. Registrar-supervisor meetings are a mix of opportunistic case review, planned topic teaching, debriefing and mentoring. Registrars attend weekly teletutorials and develop the clinical and procedural skills needed for the extended scope of remote clinical practice⁷ at twice yearly face-to-face workshops. Registrars also attend at least two accredited emergency medicine courses and with a medical educator devise an individual learning plan. Clinical teaching visitors directly observe and give feedback to the registrars in their own practice for a minimum of 3 full working days in total.

Aims

The aims of this study were to:

- document the number of years service provided in rural and remote Australia by RVTS registrars during training
- find out whether past RVTS registrars continue to provide a service in rural and remote Australia after completion of their training, and if so, using which extended skills

- document the pass rate in qualifying general practice examinations
- subjectively assess the effectiveness of RVTS training as preparation for the registrar's current practice.

Method

All registrars who had enrolled in RVTS between 1999–2005, and completed the program, were located using contact details in RVTS records, by searching the Register of Medical Practitioners maintained by the Medical Board of each state and territory, and via internet searches. The doctors were emailed an explanation of the study and given the details required to access an online survey in December 2007. Initial nonresponders were followed up by further email, telephone, fax and post. Participants were assured anonymity in our presentation of results and were asked to comment on two drafts before submission.

The RVTS senior medical educator, operations manager and research assistant compiled the research questions and designed the online survey. The survey questions asked participants where and when they trained with RVTS, their current medical practice location and service provision, and interest in continued involvement with RVTS (the latter data was of internal interest and is not presented here). The effectiveness of RVTS training was assessed subjectively using a Likert scale plus an option to make free text comments. Objective data, including the pass rate for the FRACGP and FACRRM examinations and duration of training, was determined by reviewing information on file. The survey was piloted before being sent by email to the survey participants.

Doctors' practice locations were coded according to the Rural and Remote Medical Area classification (RRMA).⁸ The research team analysed the data descriptively and the free text comments thematically.

Results

Twenty-six doctors enrolled with RVTS between 1999 and December 2005 (*Figure 1*). Two doctors chose to withdraw for personal reasons. All 24 doctors who completed the program were contacted to complete the survey and 24 (100%) responded. Twenty-three responded online and one by fax.

Service in rural or remote areas

Seventeen registrars completed all their GP training in RRMA 7 locations (*Figure 2*). The standard RVTS training program was, at the time, 3 years duration, but some registrars reduced this by successful application for recognition of prior learning. The modal number of year's service was 3; the shortest was 2. In total, 44.5 years service was provided in RRMA 7 locations during training. Five registrars trained in RRMA 5 locations and two in RRMA 4.

Current location

Six graduates work in the same location in which they completed their training – three in RRMA 7

locations (one part time). One doctor is currently overseas, another has retired and one doctor is taking a year's leave. Two graduates currently practice in three locations with different RRMA classifications.

Four graduates (one part time) continue to work in RRMA 7 locations. One works in RRMA 6, five in RRMA 5 (one part time) and six in RRMA 3. Two graduates work in RRMA 2; two are based in RRMA 1 and two work in RRMA 1 for part of the year (*Figure 3*). Overall retention rates are 17 out of 21 (81%) in RRMA 3 or above, 47% in RRMA 4 or above, 41% in RRMA 5 or above, 20% in RRMA 6 or above and 16% in RRMA 7.

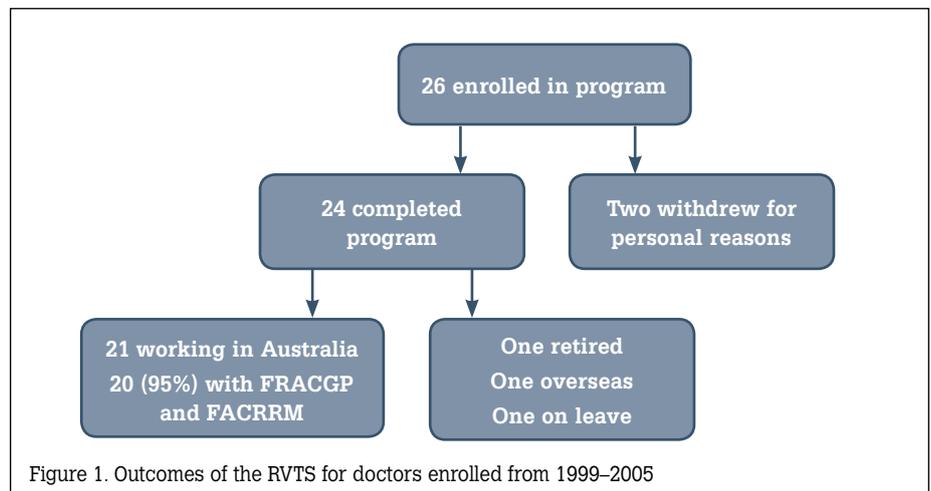


Figure 1. Outcomes of the RVTS for doctors enrolled from 1999–2005

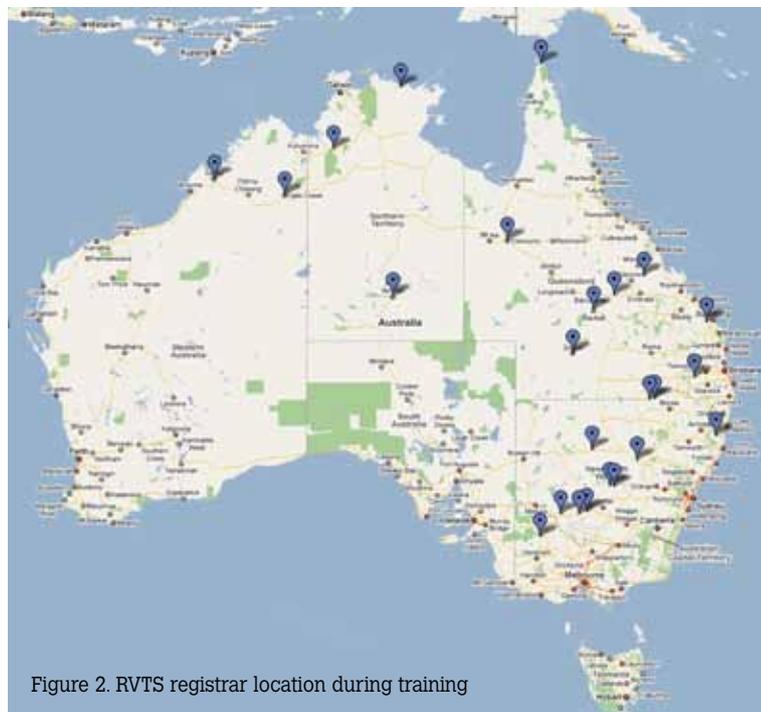


Figure 2. RVTS registrar location during training

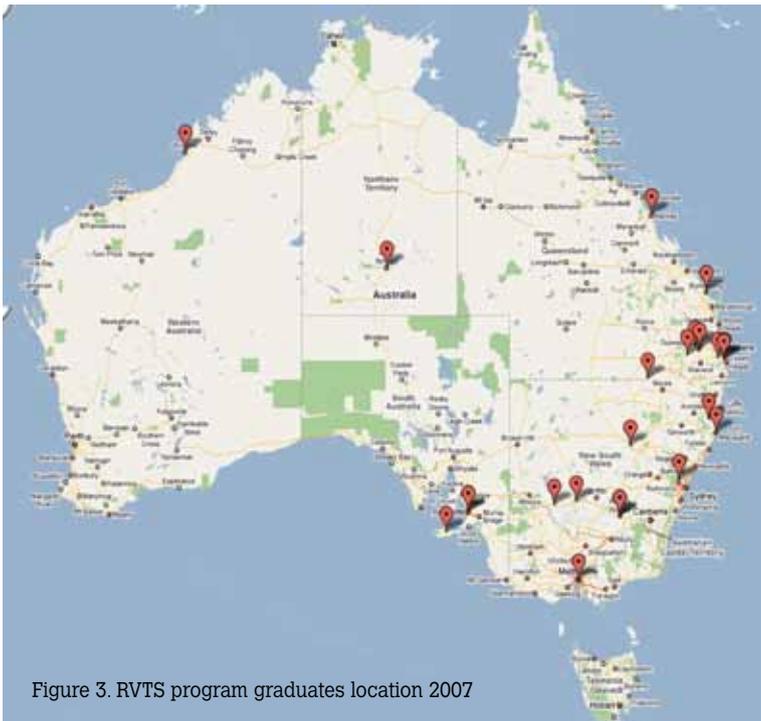


Figure 3. RVTS program graduates location 2007

Current service provision

Fourteen graduates self classified their current practice as rural medicine and 11 continue to provide emergency medical services. Three (one part time) graduates do obstetrics and five (one part time) work in the area of indigenous health. Two graduates provide surgical/anaesthetic services and one each recorded work in addiction medicine, nutritional medicine, acupuncture, visiting medical officer at a private hospital, health policy and administration, sexual health, and work with the local division of general practice.

Effectiveness of RVTS training

Twenty out of 21 doctors (95%) currently working in Australia exited the scheme with both FRACGP and FACRRM qualifications.

Regarding the effectiveness of RVTS training for clinical practice, 14 graduates felt that RVTS had prepared them extremely well, nine felt it had prepared them very well and one considered it had prepared him/her well. No one selected the options 'not so well' or 'poorly'.

Ten graduates wrote free text comments about RVTS training, all of which were positive. The themes that emerged were clinical knowledge and skills in rural, remote and emergency medicine, support, structured learning, and developing independence. Four doctors valued learning

procedural and emergency skills at the face-to-face workshops – described as 'superb' by one.

Two graduates noted the supportive nature of the program: 'For me RVTS was a life saver' and 'important to stay in town'. The program also provided 'structure in my learning'. One graduate said that the combination of supported learning while practising independently meant that they had 'gained a lot more through RVTS than the conventional path registrars'.

The comments were summarised by a graduate who trained in a RRMA 7 location: 'Very rewarding clinically, educationally, socially and in terms of supporting ongoing service provision to underdoctored remote indigenous communities'.

Discussion

The 100% response rate is excellent for a survey of GPs, giving validity to the results and confirming that internet surveys are acceptable to health professionals.⁹ One person responded by fax, so it is still important to provide alternative means of data collection. However, the positive results may have been influenced by the program graduates being reluctant to criticise their education providers.

The majority (81%) of RVTS graduates continue to work in rural areas (RRMA 3–7) after completing the program. They provide significant

emergency and obstetric services in RRMA 5–7 and five graduates work in the area of indigenous health. It will be important to compare these figures for retention after graduation in rural areas with those achieved by the regionalised Australian General Practice Training Program (AGPT) when they are available.

Despite the use of distance supervision, all past registrars believe RVTS prepared them either 'extremely well', 'very well', or 'well' for clinical practice. Graduates reported valuing the support and social network provided by the scheme as well as the emphasis on the extended skills needed in emergency and remote medicine. These results correlate with findings that the level of professional and social support influence intentions to leave or stay in rural practice^{10,11} and that improving psychological wellbeing can influence these intentions.¹² The twice yearly face-to-face workshops, to which families are also invited, may have provided an essential component in retention; of relief from on call for the whole family, and opportunity for professional development¹⁰ in the skills needed for rural and remote practice.¹³ This was achieved with program funding set at a similar level to the standard general practice training program.

As all these doctors were working in their locations before enrolling with RVTS, we cannot assess the influence of the program on their career decisions and more detailed qualitative work is planned to study this. We plan to explore the reason two registrars chose not to continue the training scheme as their critique could demonstrate significant areas for program improvement. Further research is planned on how the RVTS model of training could apply to other medical specialties and other general practice settings where registrars are in isolated practice such as the Australian Defence Force or those serving overseas in humanitarian aid projects.

Conclusion

The RVTS program of distance education and supervision, clinical teaching visits and face-to-face workshops was an effective model of general practice training for these registrars. These registrars provide significant service to rural and remote communities during and after completion of their training.

Authors

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References

1. Britt H, Miller GC, Valenti L. It's different in the bush. Joint report of the University of Sydney and The Australian Institute of Health and Welfare. Canberra: AIHW, 2001; March:1–89.
2. Humphreys JS, Jones JA, Jones MP, et al. The influence of geographical location on the complexity of rural general practice activities. *Med J Aust* 2003;179:416–20.
3. Australian Medical Workforce Advisory Committee. Doctors in vocational training: rural background and rural practice intentions. *Aust J Rural Health* 2005;13:14–20.
4. Curran V, Rourke J. The role of medical education in the recruitment and retention of rural physicians. *Med Teach* 2004;26:265–72.
5. Wing L. The Australian rural health education revolution. *Aust J Rural Health* 2007;15:344–5.
6. Piterman L. A graduate diploma in family medicine by distance education. *Med J Aust* 1992;157:178–81.
7. Smith JD, Ayton J, Ross V, et al. Defining remote medical practice. A consensus viewpoint of medical practitioners working and teaching in remote practice. *Med J Aust* 2008;188:159–61.
8. Department of Primary Industries and Energy and Department of Human Services and Health. Rural, remote and metropolitan area classification, 1991 census edition. November 1994. Available at www.pc.gov.au/_data/assets/pdf_file/0004/45724/subdr096.pdf [Accessed 7 December 2009].
9. Braithwaite DEJ, de Lusignan S, Sutton S. Using the internet to conduct surveys of health professionals: a valid alternative? *Fam Pract* 2003;20:545–51.
10. Humphreys J, Jones MP, Jones JA, Mara PR. Workforce retention in rural and remote Australia: determining the factors that influence length of practice. *Med J Aust* 2002;176:472–6.
11. Joyce C, Veitch C, Crossland L. Professional and social support networks of rural general practitioners. *Aust J Rural Health* 2003;11:7–14.
12. Gardiner M, Sexton R, Kearns H, Marshall K. Impact of support initiatives on retaining rural general practitioners. *Aust J Rural Health* 2006;14:196–201.
13. Brooks RG, Walsh M, Mardon RE, Lewis M, Clawson A. The roles of nature in the recruitment and retention of primary care physicians in rural areas: a review of the literature. *Acad Med* 2002;77:790–8.

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