Perceived stakeholder benefits of continuously training general practitioners in the same rural or remote practice: interviews exploring the Remote Vocational Training Scheme

Belinda G O'Sullivan[1,2], Patrick Giddings[3,4], Matthew R McGrail[5]

The known: Communities that retain doctors may achieve more cost-effective, quality health care, but there is limited published research on the benefits of continuously training general practitioners in the same practice in rural, remote and First Nations communities.

The new: This study explored stakeholder perspectives of the benefits of the Remote Vocational Training Scheme (RVTS), which continuously trains general practitioners in the same practices — in mostly remote communities — over periods of three to four years.

The implications: Our findings suggest that the RVTS model improves access to safe and high quality longitudinal care and contributes to service enhancements in communities that otherwise lack stable doctors.

Abstract

Objective: Explore stakeholder perspectives of the benefits of continuously training general practitioners in the same rural or remote practice in distributed locations via the Remote Vocational Training Scheme (RVTS).

Design, setting, participants: Online one-hour semi-structured interviews were conducted with 27 RVTS staff, participants and supervisors from all states and territories between 16 October and 24 November 2023. Data were deductively and inductively coded by stakeholder type and the range of benefits, and the findings were informed by insights from a project reference group and a stakeholder advisory group. Questions explored the benefits of the RVTS — a program which supports doctors already working in rural, remote and First Nations communities to train towards general practice or rural generalist fellowship while remaining in the same practice.

Main outcomes measures: Perspectives on the nature and spread of benefits.

Results: Broad benefits were perceived to flow to four system-level stakeholders: communities, health services, participants and policy makers. Perceived participant and community benefits were doctors staying longer in distributed locations with tailored place-based supports and training, doctors building relationships with patients, and doctors learning through longitudinal care. Health service benefits included reduced reliance on locums, improved continuity of accessible and appropriate services in areas otherwise facing major recruitment and retention issues, and the doctors having more time to contribute to improving service quality and upskilling local staff. Policy-maker benefits were sustaining safe and high quality services for distributed populations with high needs.

Conclusion: The RVTS model was perceived to offer diverse benefits for different system stakeholders which could improve quality of learning, service delivery and community care. It also aligned with key policy directions for a distributed and sustainable generalist workforce under the goals of the National Medical Workforce Strategy 2021–2031 and the directions set by the independent review of overseas health practitioner regulatory settings led by Robyn Kruk. However, models like the RVTS largely rely on distribution levers to recruit more doctors to the locations it supports.

Globally, rural communities rely on a distributed, skilled health workforce for access to quality health care.[1] Aligned with this, the Australian Government has consistently invested in rural doctors since the 1990s, introducing a range of national policies and plans.[2-5] However, there is limited published research on strategies which specifically target the distribution and retention of rural general practitioners and rural generalists. In this article, we explore stakeholder perspectives of the benefits of the Remote Vocational Training Scheme (RVTS), as an example of a program which continuously trains doctors in rural and remote locations to promote a more distributed, skilled and retained general practice workforce.

The RVTS is an Australian Government-funded program that has been operating since 2000.[6] The RVTS enrols doctors already working in rural and remote general practices MMM4–7 (Modified Monash Model classification with population < 15 000 people), and rural Aboriginal Medical Services (MMM2–7).[7] Since 2013, on average 82% of RVTS doctors have been international medical graduates, reflecting reliance on this group in more remote areas related to rural work moratoriums.[6] They train towards general practice and/or rural generalist fellowship while they are continuously based in small rural practices (MMM 5; 44.6%) or remote practices (MMM6–7; 29.7%) for three to four years.[6] They are supported by a holistic remote supervision and distance education model, which achieves over 90% satisfaction.[8,9] The mean time spent training in the same practice is 3.6 years, and 49% of participants remain working in the same community for up to two more years.[10] Additional data on outcomes of the RVTS are detailed in this supplement.[6,9,10]

The RVTS model aligns with the World Health Organization's global recommendations for countries to use rural-based education and training strategies and appropriate place-based personal and professional supports to recruit and retain health workers.[11] It also aligns with the goals of the National Medical Workforce Strategy 2021–2031 and the directions set by the Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners led by Robyn Kruk (hereafter referred to as the Kruk review) and targets for Closing the Gap by promoting a distributed and sustainable medical workforce for remote and rural First Nations communities.[4,12,13]

Wider research suggests that continuously training general practitioners in the same rural practice in distributed locations

[1] Rural Clinical School, University of Queensland, Toowoomba, QLD. [2] School of Rural Health, Monash University, Bendigo, VIC. [3] Remote Vocational Training Scheme, Albury, NSW. [4] Rural Clinical School, University of New South Wales, Albury, NSW. [5] School of Rural Health, University of Queensland, Rockhampton, QLD. belinda.osullivan@uq.edu.au • doi: 10.5694/mja2.52446

could achieve a culturally attuned, place-connected workforce and mitigate the costs of remote workforce turnover.[14] However, there is limited empirical evidence on who benefits and how. This makes it hard to justify continuous place-based, rural and remote training for general practice. We aimed to address this evidence gap by drawing out the views of stakeholders on how the RVTS benefits them, to inform the wider use of such training strategies.

Methods

Procedure

Online semi-structured interviews were conducted over the period 16 October to 24 November 2023. We used purposeful sampling (not pre-determined) to include as many diverse respondents as possible — RVTS stakeholders (staff, supervisors and participants) from different regions who had practical, recent knowledge of the RVTS and who were able to respond within the study timeframes. This initiation list was informed by insights of a project reference group who had working knowledge of the program. Study information was emailed to 470 people: eight RVTS staff, 24 funders and wider stakeholders, five registrar liaison and supervisor liaison officers, 338 participants (a wide range from the 2014–2023 participating doctor cohorts, of whom 105 were active, 65 had withdrawn and 168 had completed the RVTS program) and 95 current supervisors. The sampling frame was large but aimed to be inclusive and ensure that a breadth of perspectives were considered. Two reminders were sent, including mobile phone texts, to try to reach busy candidates. Participants were told who the interviewing team were, including researchers who were independent of the RVTS, and that the purpose of the study was to inform quality improvement initiatives, in order to minimise selection bias. Those choosing to participate provided written informed consent and were offered a $60 gift voucher in recognition of their time.

Interview questions were developed by the three of us and piloted with a ten-person project reference group that consisted of the RVTS executive and wider research team staff. Questions were deliberately broad to elicit a breadth of perspectives (Supporting Information). Prompts were used to promote reflection about different benefits.[10] Interviews were conducted by two experienced PhD-trained university-employed qualitative researchers (both women without medical qualifications). Interviews were conducted in a private room via telephone or video calls for about one hour, and were held at a time suiting the respondents (out of business hours where needed). Most respondents (except several RVTS staff) were not known to the interviewers; to minimise reporting bias, all respondents (regardless of whether they were known to the interviewers or not) were prompted to provide a variety of critical insights to help answer the research question. Interviewers recorded the interviews and shared individual notes with each other immediately after each interview, and no major changes were made to the interview questions. No respondents dropped out during the study and no repeat interviews were done. Transcripts were produced verbatim and all respondents were de-identified using an identification number. Quotes from the interviews are presented with respondent identification numbers and their roles (supervisor, participant and/or staff [past participants often became supervisors or staff]). In line with our aim to explore the breadth of benefits, we set out to gain a diversity of perspectives, rather than pursue data saturation. Owing to time constraints, we did not return transcripts to respondents for review.

Analysis

Thematic analysis was done over a four-month period, exploring benefits by drawing on the lived experience of respondents.[15,16] We reflected on the interview notes, read the same first few transcripts and deductively coded the systems-level stakeholder groups and high level themes, using published literature to inform this coding.[15,16] We then met to discuss and agree on the first set of codes before continuing with further coding using inductive analysis and considering the range of benefits for each systems-level stakeholder group. We continued to read each subsequent transcript, comparing notes and re-reading, to expand on the findings. This process was used to enable a consistent coding framework to emerge.[16] The analysis was done using word processing software. Thick description and triangulation were supported by referring to interview notes, and by meeting regularly as a research team, and with the project reference group and a stakeholder advisory group (a wider group of rural health executive leaders). We recorded notes from these sessions and used them to re-examine the transcripts. This assisted with the reflexivity of the analysis — supporting the testing and refinement of the final themes, and reducing any potential subjective bias.[16] The analysis was guided by qualitative research standards.[17]

Ethics approval

The project had ethics approval from the University of Queensland Human Research Ethics Committee (2023/HE001926, 24 October 2023).

Results

Participants

Twenty-seven respondents, including participating doctors and/or supervisors and/or other RVTS staff, completed an interview (Box 1). The interview respondents included a mixture of women and men, and people of different ages, roles and locations.

Themes

Consistent overarching themes were identified — that the RVTS benefits were distributed across four system-level stakeholders of communities, health services, participants (participating doctors) and policy makers. A diverse range of themes by stakeholder type was also identified (Box 2).

Communities

Communities with limited resources that needed doctors were perceived to benefit from being able to access a doctor with education supports "in place": "a lot of locations that haven't had a doctor for many years … their first doctor … is … through the RVTS" (ID9/supervisor). A benefit of the model was that the community could access the skills and training focus and the stability of the doctor: "The benefit to the community is the doctor gets good training and stays in the community" (ID13/supervisor). The doctors were also noted to have strong background experience, critical for quality services in these settings: "she brought a whole range of skills [providing] really critical [services] for that community" (ID10/supervisor). As a retention program, doctors connected to the community for longer term impact, and some intended to stay: "over that time she has done a lot for the community and their health care … she wants to stay" (ID16/supervisor). Therapeutic relationships were enhanced by the retention focus: "staying in the same location,

1 Characteristics of interview respondents (*n* = 27)

Characteristic	Number (%)
Sex	
Women	18 (67%)
Men	9 (33%)
Age group (years)	
30–49	15 (56%)
≥ 50	12 (44%)
Role*	
Supervisor	11 (37%)
Participating doctor	14 (47%)†
RVTS board or other staff	5 (17%)
Location	
Australian Capital Territory or New South Wales	9 (33%)
Queensland	8 (30%)
Other	10 (37%)
Modified Monash Model (MMM) category	
MMM1–3	14 (52%)
MMM4–7	13 (48%)

RVTS = Remote Vocational Training Scheme. * Percentages shown are the percentages of all roles (multiple roles possible). † Five current participants (two Australian medical graduates and three international medical graduates) and nine past participants (all international medical graduates). Due to the remote education model of the RVTS, interview participants do not reflect the distribution of program participants.[6,10] ◆

2 Summary of benefits of the Remote Vocational Training Scheme (RVTS) continuously training general practitioners in the same practice in rural, remote and First Nations communities

System level	Benefits described
Communities	• High need, low resource communities have a doctor who is actively upskilling through training in place for three to four years, supported by high quality resources • Community connection and impact are better because the doctors are invested in local population health issues for longer • Relationships develop, building rapport and trust in health care and the capacity to affect health outcomes
Health services	• Longer term doctors establish new clinics and train other staff • Reliance on locums is reduced (service approachability is improved) • Culturally responsive effective care is enhanced (service acceptability is improved)
Participants	• Depth of learning, improved confidence, and trust from building relationships with ongoing patients • Sense of purpose for providing essential services • Preservation of energy because doctors do not need to move locations* • Retention of entitlements for maternity and long service because doctors stay with a single employer* • Training and support that are specific to the needs within the practice and place
Policy makers	• Closing the Gap in Indigenous health • Improving the safety and quality of rural and remote services through oversight of international medical graduates and isolated doctors • Qualified general practitioners, retained in distributed locations for sustaining primary care access†

* Compared with rotating for training. † Affected by policies regarding use of a migrant workforce and their expected distribution and wider policies targeting the distribution of doctors in the locations supported by the RVTS. ◆

you see the same patients and you establish rapport" (ID25/participant). This related to higher quality of care and visible outcomes: "they tell me more because I am there for longer … I can see their health improve" (ID7/participant).

Health services

Health services were perceived to benefit by the increased continuity of staffing, which helped with quality improvement and upskilling of other health workers: "I stayed there for three years. By the end of it I had trained the midwife … and we set up the clinic" (ID25/participant). The model also reduced the reliance on locums for more approachable services in these locations: "Locums are the main alternative, and they simply don't compare; they come in for a short period of time and no one wants to see them because they know you are short term … a band aid" (ID16/supervisor). Health services had the opportunity to draw on stable doctors to develop more culturally responsive effective team care: "the Aboriginal Medical Services can practice much more effectively" (ID9/supervisor).

Participants

The perceived benefit for participating doctors included an improved depth of learning by observing patients over life stages: "you know, seeing as a registrar that cradle to grave play out in your training … I think that gets lost when you change from place to place" (ID26/participant/staff). Doctors were considered to have gained confidence as emerging professionals with trusted patient relationships: "a good book of patients who regularly see me … they have confidence in seeing you" (ID7/participant); "a sense of longevity and the trust from the community" (ID14/participant). This was contrasted with rotational training models: "you do a degree, you've got terms, rotations that you do … You spend a great deal of time when you're in the location preparing for the next location" (ID14/participant). Moving around for training was noted to undermine trainee entitlements: "[other training programs] … they change practice every six to 12 months, and they lose all their accrued entitlements every single time" (ID6/staff). Participants also enjoyed the place-based resources which promoted resilience for working in the specific location: "the RVTS is location specific … you have the support and guidance linked to your job, with support to get through each stage" (ID7/participant).

Policy makers

The perceived benefit to policy makers included improving continuity of services for rural and remote First Nations communities: "Having worked in Indigenous health for 25 years, the most important thing in Indigenous health, aside from cultural safety, is continuity of carer" (ID6/staff). The model was also considered to enable safety and quality of care and equitable access to training and resources for international medical graduates in these settings: "The 10-year moratoriums are not working if they put all these doctors out there with no preparation … they are burning out rural doctors" (ID27/supervisor). It was also considered to support access to quality training for safe practice: "getting through their exams

successfully, getting a fellowship, and being safe, competent GPs" (ID6/staff). In addition, it was considered to support better distribution of doctors: "[an] incentive for doctors to be really remote" (ID3/participant). However, the RVTS model relied on the supply of enough doctors through recruitment to sites eligible for RVTS support: "if overseas trained doctors don't support rural towns, we [the RVTS] would be out of doctors" (ID19/staff).

Discussion

In this study, we identified a wide range of perceived benefits to different systems-level stakeholders from the RVTS' approach of training general practitioners and rural generalists continuously in the same rural and remote practices. The findings reinforce that this approach could benefit a culturally attuned, place-connected workforce and mitigate the cost and time related to remote workforce turnover. The beneficiaries included communities, health services, participating doctors and policy makers — the latter because training continuously in rural and remote practices under the RVTS was considered to support multiple workforce policies.

Training continuously in the same practice was thought to provide more time for engagement in developing new service models, and also enhance relationship-based care in locations with access, quality and sustainability challenges. Improved stability of doctors in these settings was considered to improve the availability, approachability and acceptability of care, which are critical dimensions of patient-centred health care models.[18] Findings of other research suggest that retention-focused workforce strategies support high value care through stronger therapeutic relationships between doctors and patients.[19,20] They can also improve workforce stability in small towns that normally experience high turnover.[21] Our findings suggest that in longer term relationships, patients may feel more comfortable disclosing issues which are critical for relevant and timely primary health care and for achieving health outcomes.

The results of our study also suggest that the RVTS approach of continuously training in rural and remote and First Nations communities could reduce locum costs; this is important because other research has shown that staff turnover is projected to cost up to $32 million annually in the Northern Territory.[22] Another benefit to policy makers was that the RVTS model is suitable for supporting safe and supported practice by international medical graduates, many of whom work in rural areas on ten-year moratoriums.[23] International medical graduates are a major source of workforce for rural areas and they need to be recognised and equitably supported according to an international code on migrant health workers.[24,25] The RVTS approach is also a potential solution which can be applied to assist with the goals of the National Medical Workforce Strategy 2021–2031 and recommendations of the recent Kruk review for a distributed, skilled and sustained rural medical workforce.[4,12] Another area of policy that the RVTS model aligns with is the single employer model for attracting registrars to general practice.[26] Our findings suggest that continuous training in the same location could benefit participating registrars by preserving their energy and employment entitlements.

More continuous training in distributed rural locations is a challenge for government, training providers and communities. The Australian Government is committed to promoting longer term end-to-end rural training and more remote training opportunities in the same regions for medical students.[3,4,27] However, under the current model trainees mostly move between practices and towns, which may not build the strength of relationships which are possible when they remain in the same practice over several years. Further, despite many opportunities to step through rural pre-vocational and vocational work and training, and to take part in longer rural immersion programs, many doctors choose to leave or only do some rural rotations.[27,28] Countering this, place-based training and coordinated support for a cohort doing rural internships in one MMM4–7 region in Victoria identified good retention in the same region and resulted in 61% of participants pursuing general practice careers up to ten years later — well above wider benchmarks in the literature.[29] Rural generalist training pathways use coordination and case workers to support rural career navigation and promote regional retention but many training options require or result in rural doctors moving around.[5,28,30] This could change if postgraduate work and training models had clear distribution and retention targets, such as focusing on specific populations or high need areas as the RVTS does.[6] The RVTS provides an example of a tailored and adaptable model to train and holistically support doctors who are continuously based in distributed locations.[6,9,10] It may not be applicable in all settings and specialties, but it provides a source of reflection for training organisations and rural workforce policy makers.

It is possible that the beneficiaries and the range of benefits identified in this study would be slightly different for non-general practice specialties because of their different roles and technical requirements. However, more continuous training in non-general practice fields could be developed by working with regional level champions to find opportunities, and by leveraging investment from Australian Government-funded initiatives (eg, the Specialist Training Program, the Integrated Rural Training Pipeline and regional training hubs).[31] Place-based training in the non-general practice specialties is important to foster regional service hubs that have greater critical mass for sustaining outreach services for outlying rural and remote communities.[28,32,33] An example of expanded place-based training for specialist care is a general practice obstetrics model was described in Gippsland; it involved a structured regional pathway linked with wider specialist units and practice opportunities.[34]

Despite the potential benefits of the RVTS model, our findings suggests that this model relies on distribution levers to support the recruitment of doctors to rural and remote areas where it operates. As such, it is likely to rely on other government initiatives such as the Distribution Priority Area policy and Bonded Medical Program to facilitate more critical mass in the target areas.[35,36] Currently, local medical graduates can complete the Bonded Medical Program through part-time, fly-in/fly-out options in any rural area.[36] This may not promote the distribution or continuity of domestic workforce in areas where the RVTS trains.

A limitation of our study is that it was small and included a pool of respondents who may have had positive bias as they were mainly internal RVTS-affiliated staff and supervisors. Only a small proportion of the overall pool who were invited to participate enrolled in the study, possibly because most of the invited candidates were doctors with limited discretionary time to read about the study and participate in the interview. The questions were positively framed around the benefits and the researchers were aware of the RVTS' publicised success, which potentially biased the research. The barriers and challenges to this model should therefore be explored in more depth as part

of ongoing research. In addition, while respondents identified a range of benefits in line with the research question, further exploration may be needed to reach data saturation. Further research could also explore the perspectives of community members, health services and wider stakeholders, and involve more direct comparison with programs that are not continuously training general practitioners in the same practice, to examine the benefits and disadvantages of the RVTS approach. Finally, our results are limited to one program, although the RVTS is a unique model for studying the benefits of continuously training general practitioners in the same practice.

In conclusion, the RVTS model, which involves continuously training general practitioners and rural generalists in the same practice in mostly remote and distributed locations, was seen as beneficial for low resource communities. Its approach has enabled these communities to access doctors who receive supported training over a three to four-year timeframe which contributed to improvement of service quality and overall skills of rural, remote and First Nations health care teams. Participants believed that continuous training in a single practice offered opportunities for deeper learning and the provision of longitudinal care, ultimately leading to better health outcomes. The model is likely to be acceptable and contextually relevant for promoting a distributed and supported generalist workforce that is aligned with the goals of the National Medical Workforce Strategy 2021–2031 and directions of the Kruk review, among other policy areas. However, continuously training general practitioners in the same rural and remote practices relies on distribution levers, including regulatory strategies and distribution targets to build capacity.

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Data sharing: The de-identified data we analysed are not publicly available, but we will seek to provide data through requests to the corresponding author which will be considered on a case-by-case basis.

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Supporting Information

Additional Supporting Information is included with the online version of this article.