

Chapter 3.2.1

RURAL MEDICAL TRAINING VIA DISTANCE EDUCATION AND REMOTE SUPERVISION

Patrick Giddings

Jeanette McLaren

Remote Vocational Training Scheme, Australia

Introduction

The purpose of this chapter is to present the experience of delivering rural and remote general practice (GP) training offered through distance education and remote supervision.

The Remote Vocational Training Scheme (RVTS) was established in Australia as a pilot in 2000. The programme is for doctors practising in remote communities who would otherwise have to leave their community in order to undertake training. Training is delivered by distance education and remote supervision over three to four years (1). The training programme is in its 13th year, having been delivered to 167 doctors in 150 communities since its inception in 2000. On completion of the training more than 92% of participants have achieved vocational qualifications in general practice.

The programme has also been a successful workforce retention strategy with 84% of graduates remaining in a rural area, with 39% still being in the community in which they trained more than two years after completing the programme. RVTS therefore is primarily a workforce retention programme with its *modus operandi* being educational support to GP fellowship qualifications.

Qualifications for GPs

How is it possible to work as a general practitioner in Australia without recognised qualifications in that field?

Since 1996 there has been a requirement for doctors working as GPs to have recognised qualifications in order to be able to participate in the national health insurance scheme, Medicare. Exceptions are made in areas of workforce need - usually rural and remote parts of the country (2) - such that at least 1 900 doctors working in rural and remote communities are estimated to be working under these arrangements (3). This group is made up of both Australian graduates and doctors who gained their primary medical qualification in other countries.

Despite the significant increase in the expected number of medical graduates in Australia, there is likely to be an unmet demand for medical workforce in rural and remote areas well into the next decade (4).

Practice pearls

Key issues

- Excellent outcomes from training in family medicine/general practice via distance education and remote supervision is possible.
- Education and training support translates into high levels of workforce retention.

Lessons learned

- Family support as part of the training package is highly valued.
- It is important to make doctors feel as though they are part of a special group.
- Regular contact with a critical mass of people in similar situations is important.
- A flexible approach is required to account for the variable situations that remote doctors find themselves in.
- It's not for everybody.

What to do

- Better suited to more experienced doctors.
- Face-to-face meetings of participants early in the training programme to promote group cohesiveness, then at least twice per year.
- Emergency medicine skills updated in each face-to-face meeting.
- Try to pair learners with supervisors in the same region with similar practice populations and referral patterns.
- Regular contact with a medical educator.
- Regular clinical teaching visits.
- Keep technology as simple as possible.
- One-on-one training in technology, if necessary.
- Fun social events at face-to-face meetings.

What not to do

- High tech distance education solutions that require on-site technical support.
- Supervisors that are employers or line managers – as conflicting roles can compromise the educational relationship.

Evidence and discussion

GP training via remote supervision was described in the 1990s (5). In response, a pilot training programme was established in 1999 for a limited number of participants (6) and was transformed in 2003 into the Remote Vocational Training Scheme (RVTS) (7). In 2007, the programme was extended to accommodate annual cohorts of trainees (1). To date, 167 doctors have been trained and 150 isolated communities have had the services of a doctor who has been supported in this way.

RVTS as a retention strategy

A review of the literature has revealed broad agreement that education and training are important factors in the recruitment and retention of the medical workforce in rural and remote practice, though there is little direct evidence to support this assertion (8). Wearne et al (9) examined the retention of doctors who had completed the RVTS and in 2010 reported that 81% of graduates were continuing to work in a rural area. More recent data from RVTS provides consistent findings - with 84% of completed trainees continuing to work in a rural area, while 39% were still

in the community in which they trained more than two years after completing the programme (10).

While remote medical practice has many rewards, there are multiple factors that can contribute to doctors leaving. Professional isolation, lack of opportunities for career progression and a sense of being undervalued by the rest of the profession contribute to low morale and poor workforce retention (11, 12). So how has RVTS been such a successful retention strategy? Qualitative data collected from participants may provide some clues (13).

What trainees said

The importance of being linked into a collegial network is highlighted by the following quotes:

"(RVTS) helps me stay in touch with colleagues and professional issues and mainstream thinking whilst 'out there'."

"(RVTS) helps with difficult clinical decisions, knowing I have a 'friend a phone-call away'."

"Mainly good to have the opportunity to debrief with like-minded people. Also it is nice to be a name, not a number, in a small organisation."

"I think the support that RVTS provides is the most important thing. I feel very supported. I feel that I am part of something. The help is there if you need or want it."

The impact of collegial support on retention is evident in the following:

"I wouldn't have stayed as long if I didn't have support from my supervisor and RVTS."

Participants respond to being valued for the specialised work that they undertake. Positive self-regard is reinforced by a sense of being part of a special group (14).

Family support is a well-documented contributor to the retention of rural and remote doctors (12, 15). Internal programme evaluation suggests measures to support the families of registrars have been key contributors to the success of the programme (6, 16). The immediate family of doctors training with RVTS are supported to attend twice yearly five-day education workshops. The workshops are purposefully held in major cities allowing families to enjoy their many attractions.

Child care and peer support is provided with the help of rural medical family support networks.

Suitability

While remotely supervised training via RVTS has been a successful retention strategy, this approach to training is unlikely to suit everyone. Participants in RVTS are older and more experienced. The average age of participants at entry is 39 (27-64) with the average number of years since attainment of primary medical degree is ten years(4-37) Eligibility for RVTS training requires doctors to already be working in a remote setting, thus demonstrating a preparedness to work in a relatively unsupported isolated environment.

So who is best suited to the remote training model? There is very little knowledge of how to identify individuals best suited to the remote training model and the literature in relation to personal attributes of rural and remote learners is very limited – with the small numbers of studies having examined the personality profiles of rural and remote practitioners general.

Eley (17) suggests that rural and remote male general practitioners appear to have personalities that give them a higher tolerance to risk and a tendency towards sensation or novelty seeking. These traits appear to be less represented among female rural and remote general practitioners. Other studies have found that remote GPs had significantly higher sensation-seeking traits than the population norm (18). The authors are unaware of any studies that examine the personal attributes of rural and remote GP learners.

Illustrative case study

At age 53 and in his 30th year post graduation, PB had been practising in a large city hospital environment for more than two decades. A desire for career change prompted PB to obtain a position in a remote aboriginal community in central Australia, comprising a population of around 250 with 1 000 in the surrounding area.

PB was the only doctor supported by two or three nurses. His new practice was isolated, with the nearest medical colleague being 150 km away and the nearest hospital with surgical, anaesthetic and obstetric facilities being 400 km away.

PB had no general practice/family medicine qualifications at that time. Joining RVTS was the only practical way to train towards specialist GP qualifications via distance education and remote supervision. “RVTS gave me the skills and confidence to practice in a new environment and to tackle the examination and assessment events” (19).

Weekly tele-tutorials with fellow registrars were a welcome opportunity to network with others and to ‘brush up’ on knowledge. PBs off-site supervisor was a doctor with significant experience of working in a similar environment and was based in the regional centre 400km away.

PB was able to stay in his community for the duration of his training and continues to practise in isolation after seven years. He received specialist qualifications in general practice at the completion of his training with RVTS and stays in touch with his RVTS colleagues via the programme’s alumni network.

Broader applicability and implementation

Training in situ as a workforce retention strategy has applicability wherever workforce and training needs coincide. The approach described in this paper is especially applicable in environments where supervision is difficult. Examples include rural and remote environments, indigenous communities and developing countries.

RVTS is extending its training model to doctors working in aboriginal medical services (20), many of whom, despite being located in larger urban centres, are unable to access adequate on-site supervision for GP training (21).

The World Health Organization states that there is a global deficit of at least 2,4 million doctors, nurses and midwives (22). A Canadian organisation is using a similar distance education model to the one described here, to deliver postgraduate training to more than 500 doctors in Sudan via the Global Medical Family Medicine Residency Programme (23). RVTS-style training for doctors in Pacific island countries has been proposed (24).

With the success of RVTS using remote supervision and distance education, the need to extend the model to other health disciplines has been raised (25). Hays (26) suggests that an interdisciplinary approach to supervision recognises the role of the multidisciplinary team in remote medical services and the formalisation of the interdisciplinary supervision that already occurs in remote settings, with experienced nurses providing supervision for junior doctors.

Conclusion

Education and training can be important in the retention of rural and remote doctors. An Australian programme that delivers rural and remote GP training via distance education (RVTS) has been successful in practitioners achieving qualifications as well as in high levels of workforce retention. Membership of a collegial group and support for families of training doctors have been identified as important factors in this. Training in isolated settings is not for everybody, however, and participants in the RVTS are older and more experienced than would be expected of a group of doctors in training.

The adaptability of the RVTS training model makes it suitable for broader application across medical specialties, health disciplines, and training environments.

References

1. *Remote Vocational Training Scheme: RVTS*. www.rvts.org.au (accessed 2013).
2. Rural & Regional Health Australia. *Rural Locum Relief Programme (RLRP)*. Australian Government Department of Health and Ageing. www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/Rural_Locum_Relief_Programme (accessed 13 November 2012).
3. Department of Health. *Section 3GA workforce programmes Canberra*. Australian Government; 2012. www.health.gov.au/internet/publications/publishing.nsf/Content/work-report-review-medicare-provider-number-legislation-toc~work-report-review-medicare-provider-number-legislation-chap-five (accessed 14 October 2013).
4. Health Workforce Australia. *Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1*. Adelaide 2012. www.hwa.gov.au/sites/uploads/health-workforce-2025-volume-1.pdf (accessed 14 October 2013).

5. Hays RB, Peterson L. Options in education for advanced trainees in isolated general practice. *Australian Family Physician* 1996; 25(3):362-366. PubMed PMID: 8867188.
6. Veitch C, Crossland LJ. *Formative evaluation of the pilot remote vocational training stream*. Rural Health and Workforce Research Unit, School of Medicine, James Cook University, Townsville, Australia. 2000.
7. Giddings P. Remote Vocational Training Stream. 2006. *Outback*. Doc 3(4):9-11: www.acrrm.org.au/files/uploads/pdf/newsletters/outbackdoc/downloads_Outback%20Oct-Dec%202006.pdf www.hwa.gov.au/sites/uploads/health-workforce-2025-volume-1.pdf (accessed 14 October 2013).
8. Humphreys J, Wakerman J, Wells R, Kuipers P, Jones J, Entwistle P, Harvey P. *Improving primary health care workforce retention in small rural and remote communities: how important is ongoing education and training?* Australian Primary Health Care Research Institute, 2007.
9. Wearne S, Giddings P, McLaren J, Gargan C. Where are they now? The career paths of the Remote Vocational Training Scheme registrars. *Australian Family Physician* 2010; 39:53-56.
10. Giddings P. Where are they still? The Remote Vocational Training Scheme and workforce retention. Presented at the Remote Medical Education Conference. Sydney, Australia. 28 July 2012.
11. Van Dormael M, Dugas S, Kone Y, Coulibaly S, Sy M, Marchal B, et al. Appropriate training and retention of community doctors in rural areas: A case study from Mali. *Human Resources for Health* 2008; 6:25. PubMed PMID: 19017381. Pubmed Central PMCID: 2621240.
12. Hays RB, Veitch PC, Cheers B, Crossland L. Why doctors leave rural practice. *The Australian Journal of Rural Health* 1997; 5(4):198-203. PubMed PMID: 9444118.
13. Remote Vocational Training Scheme. Registrar Satisfaction Survey. 2011.
14. McLaren J. What's Important – lessons from the successes of RVTs. Presented at the Remote Medical Education Conference. Sydney, Australia. 28 July 2012.
15. Veitch C, Crossland LJ. Medical family support needs and experiences in rural Queensland. *Rural and Remote Health* 2005; 5(4):467. PubMed PMID: 16285846.
16. Mugford B, Togno J, Jones R. *Pilot Remote Vocational Training Stream (PRVTS) Final Evaluation*. Monash University School of Rural Health & Flinders University Rural & Remote Community Clinical School, 2003.
17. Eley D, Young L, Przybeck TR. Exploring the temperament and character traits of rural and urban doctors. *Journal of Rural Health* 2009; 25(1):43-9. PubMed PMID: 19166560.

18. Price M. Are remote GPs sensation seekers? Presented at RACGP Annual Scientific Conference. Darwin, Australia. 2006.
19. Rural Doctors Association of Australia. GP fellowship at 57! *Rural Pulse* 2012 January:28 -9.
20. NACCHO Aboriginal Health News Alerts (Internet): *National Aboriginal Community Controlled Health Organisation*. 2013.
<http://nacchocommunique.com/2013/10/04/naccho-health-training-newsgp-training-extended-to-aboriginal-community-controlled-organisations/> (accessed 14 October 2013).
21. General Practice Education and Training Ltd. *Aboriginal and Torres Strait Islander Health Training Capacity Assessment Report*. Canberra, Australia. 2012.
22. World Health Organization. *Task shifting to tackle health worker shortages*. World Health Organization; Geneva, Switzerland. 2007.
www.who.int/healthsystems/task_shifting_booklet.pdf (accessed 14 October 2013).
23. McCaskill A, Anderson E, Franks E. NextGenU.org and the Global Family Medicine Residency Programme. Presented at the Remote Medical Education Conference. Brisbane, Australia. 29 June 2013.
24. McIver L, Launching the ROCCT-SHIP. Remote opportunities for consultation, clinical training and support for health in the Pacific. Presented at the Remote Medical Education Conference. Brisbane, Australia. 29 June 2013.
25. Mason J. *Review of Australian Government Health Workforce Programmes*. Department of Health and Ageing; 2013 April.
www.health.gov.au/internet/main/publishing.nsf/Content/review-australian-government-health-workforce-programmes (accessed 14 October 2013).
26. Hays RB. Remote supervision of health professionals in areas of workforce need: Time to extend the model? *Rural and Remote Health* 2012; 12:2322.
www.rrh.org.au/publishedarticles/article_print_2322.pdf. PubMed PMID: 23106393 (accessed 14 October 2013).

Further reading

1. Wearne S, Dornan T, Teunissen PW, Skinner T. Twelve tips on how to set up postgraduate training via remote clinical supervision. *Medical teacher* 2013 Jun 19. PubMed PMID: 23782042.
2. Hays R. *Remote clinical supervision. Practice-based teaching. A Guide for General Practitioners*. 2nd ed. Melbourne: Eruditions Publishing; 2006. p.121 - 128.

This article is a chapter from the **WONCA Rural Medical Education Guidebook**.
It is available from www.globalfamilydoctor.com.

Published by:
WONCA Working Party on Rural Practice
World Organization of Family Doctors (WONCA)
12A-05 Chartered Square Building
152 North Sathon Road
Silom, Bangrak
Bangkok 10500
THAILAND



manager@wonca.net

© Giddings P, McLaren J, 2014.

The authors have granted the World Organization of Family Doctors (WONCA) and the WONCA Working Party on Rural Practice permission for the reproduction of this chapter.

The views expressed in this chapter are those of the authors and do not necessarily reflect the views and policies of the World Organization of Family Doctors (WONCA) and the WONCA Working Party on Rural Practice. Every effort has been made to ensure that the information in this chapter is accurate. This does not diminish the requirement to exercise clinical judgement, and neither the publisher nor the authors can accept any responsibility for its use in practice.

Requests for permission to reproduce or translate WONCA publications for commercial use or distribution should be addressed to the WONCA Secretariat at the address above.



Suggested citation: Giddings P, McLaren J. Rural medical training via distance education and remote supervision. In Chater AB, Rourke J, Couper ID, Strasser RP, Reid S (eds.) *WONCA Rural Medical Education Guidebook*. World Organization of Family Doctors (WONCA): WONCA Working Party on Rural Practice, 2014. www.globalfamilydoctor.com (accessed [date]).