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Optimising Longer-Term Training for General Practitioners in Rural Aboriginal Medical Services

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ABSTRACT

Aims: This commentary explores the evidence and experience of the Remote Vocational Training Scheme (RVTS) to reflect on the long-term training of general practitioners (GPs) and rural generalists (RGs) within rural Aboriginal Medical Services (AMS).

Context: Aboriginal Community Controlled Health Organisations (ACCHOs) and their AMSs provide culturally informed, holistic health services that directly and indirectly address a breadth of primary and preventative healthcare for First Nations communities. However, commonly only short-term and specialised GP/RG training posts are available in these settings, which contrasts with the continuity of care and stable workforce often required in First Nations communities. The Remote Vocational Training Scheme (RVTS) has over 10 years of evidence and experience in implementing a rural AMS training stream, providing 3–4 years of continuous training for GPs/RGs based in the same AMS.

Approach: This paper reflects on the lessons learnt by the RVTS leadership team and the evidence from an independent evaluation to inform longer-term training of GP/RGs in rural AMSs across the sector. At the time of the evaluation in November 2023, the AMS stream had enrolled 71 doctors, 36 of whom had completed training in the same AMS, with 14 participants still in training. The commentary offers valuable insights into the design, delivery and outcomes of the program, providing guidance for broader implementation of longer-term training.

Conclusion: Longer-term rural AMS training provides valuable learning to trainees whilst ensuring continuity of care and medical workforce stability for First Nations communities. It could be enhanced by incorporating selection and training conditions that prioritise holistic, retention-focused support for trainees.

This commentary discusses the potential to increase longer-term general practice (GP) and rural generalist (RG) training in rural Aboriginal Medical Services (AMSs). The article is informed by published findings from an independent evaluation of the Remote Vocational Training Scheme (RVTS) conducted by the University of Queensland in 2023–24, reported in a series of publications (referenced throughout). These findings are complemented by reflections and insights from the RVTS leadership team based on over 10 years of experience with implementing longer-term GP/RG training in rural AMSs.

1 | What Is the Need?

Regional, rural and remote areas constitute 28% of the Australian population and 65% of the First Nations populations [1]. Rural and First Nations populations have the greatest relative need for culturally safe medical services and stable primary health care, due to a higher burden of complex care and preventable hospitalisations [2]. First Nations communities and Aboriginal Community Controlled Health Services (ACCHs) in rural and remote areas need culturally competent health workers with

Key Points

- Longer-term GP/RG training (3-4 years) with Aboriginal Medical Services(AMSs) enhances continuity of care and supports culturally safe, relationship-based practice in First Nations Communities.
- Remote supervision combined with structured education and cultural mentoring enables effective GP/RG training in rural AMSs where on-site supervision is limited.
- Improving GP/RG retention in AMSs requires careful trainee selection and holistic support strategies, including clear expectations, mentorship and wellbeing support.

experience of holistic primary healthcare, who can connect and build rapport with the community for service access [3, 4]. However, ACCHs are commonly reliant on recently arrived international medical graduates (IMGs), locum doctors and short-term general practice (GP) and Rural Generalist (RG) trainees [5], leading to high staff turnover and reduced continuity of high-quality primary health care.

Australia is heavily invested in building a culturally competent medical workforce, with cultural safety now a core part of the medical curriculum [6]. Enthusiasm for First Nations work as part of medical careers is also high (51% of national medical students surveyed in 2023 indicated an interest) ($n = 951/1878$; 58% response rate) [7]. However, only 5% of 2769 GP trainees responding to the 2024 Australian Medical Training Survey worked (partly or mostly) in Aboriginal and Torres Strait Islander healthcare services [8–10] and only 4% of Australia's 34 449 GPs work in First Nations settings [10]. There are likely to be a number of reasons for this, including the smaller volume of AMSs compared with accredited general practices across the country ($n = 148$ vs. 7135) [9, 10]. However, the level of uptake of GP work in First Nations settings also suggests that GP training within ACCHSs may be underdeveloped. It transpires that expanding longer-term GP/RG training within AMSs is important since doctors working in AMSs have the highest satisfaction (88%) compared with other GPs, including those in group practices (73%) [10].

Whilst the community-led interest of AMSs is critical within this discussion, GP training bodies also need to engage with opportunities for longer-term GP training in this setting. Box 1 shows that the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) collaborating with the Joint College Training Services, aim to develop opportunities for training in AMS settings but do not specifically target longer-term posts. The RACGP requirements for practice diversity may influence trainees to move between shorter-term posts [11]. ACRRM has flexible training options and trainees may choose to stay in rural AMSs or move through several posts for their RG training requirements [12]. With both colleges, trainees may complete a year of advanced specialised training in Aboriginal and Torres Strait Islander Health [11, 12]. Aligning GP/RG training posts with the specific needs of First Nations communities might see greater prioritisation of longer-term placements in rural AMSs for longitudinal relationship-based care for First Nations peoples [13–15].

BOX 1 | Australian General Practice Training [11].

The Royal Australian College of General Practitioners (RACGP's) Australian General Practice Training handbook states that trainees are 'expected to work in a range of general practice activities... [and] see patients from a range of demographics (e.g. age, gender) and with varied presentations'. Hence, during training terms 1, 2 and 3 (each 6 months) and the 6 months extended skills (making up 2 years of overall community-based training), trainees need to experience:

- Two different supervisors.
- Two different business models.
- Diverse patient populations.

There are also options for 6-month extended skills term to focus on special interest areas like First Nations medicine. Also, the RACGP's rural generalist 'additional skills training' involves an extra 52 weeks, which can be spent in Aboriginal and Torres Strait Islander Health (one of six non-procedural disciplines available with the RACGP).

Australian College of Rural and Remote Medicine [12].

The Australian College of Rural and Remote Medicine (ACRRM) has options to train in First Nations posts particularly for core generalist curriculum community primary care or rural and remote practice in Modified Monash Model (MMM) 4–7 and/or provides a minimum 12 months of Aboriginal and Torres Strait Islander Health Advanced Specialised Training [21].

Joint College Training Services [22].

Joint College Training Services were created in 2022 as a joint venture of the RACGP and ACRRM to support GP training across the ACCHO sector and to nurture and grow doctors capable of First Nations healthcare. They focus on cultural safety through a First Nations-led Cultural Educators and Cultural Mentors' Network who are First Nations community members that connect with trainees to support their cultural safety and their understanding and connection with local First Nations communities.

2 | RVTS Model for Longer-Term Training

The Remote Vocational Training Scheme (RVTS) Ltd. is a national provider of rural-based, retention-focused GP/RG training in partnership with the RACGP and ACRRM. The RVTS has more than 10 years of experience in managing a unique rural AMS stream (aiming for 10 participants per year) alongside its longstanding remote stream. This involves recruiting and supporting GP/RG trainees who are continuously based in AMSs for 3–4 years of training [16]. The AMS model offers valuable insights for expanding longer-term training opportunities in rural AMS settings.

Between 2014 and 2023, the RVTS has enrolled 71 doctors in the AMS stream involving 3–4 years of continuous GP/RG training in AMSs around Australia. In this period, these places have contributed to around 20% of all the RVTS' enrolments, with the

remainder training in the remote stream which runs alongside the AMS stream. A 2023–2024 independent evaluation of the RVTS published in the Medical Journal of Australia in 2024 provided broad evidence about the RVTS outcomes. However, this commentary specifically reflects on the AMS stream [16–20].

Being a training provider with the aim of workforce retention, doctors joining the RVTS' AMS stream are only eligible if they are already employed in an AMS in an eligible location (initially permitted in MMM1 but MMM2-7 since 2019) [21]. The AMS stream participants have a mean of 1.0 years prior experience in the location, compared with 1.9 years for the 'remote' stream cohort [17].

The RVTS leadership team reflected that many AMSs have insufficient doctors with fellowship qualifications to provide on-site supervision. The RVTS uses remote supervision and distance education to overcome this barrier [16]. Underpinning this model, the RVTS targets eligible candidates who are assessed as safe to work without supervisors onsite with competencies as mature and reflective learners [16]. RVTS uses off-the-shelf technology to deliver online learning resources, webinars and peer chat groups [18]. Additionally, AMS trainees attend twice yearly fully funded multi-day, face-to-face skills-based workshops with remote stream participants. Within the RVTS model, supervisors provide longitudinal clinical oversight, assessment and case-based guidance, while medical educators focus on curriculum delivery, learning progression, examination preparation, and professional development support [18]. The evaluation suggested the RVTS' supervision model was broader than competency development and extended to promoting trainees who felt comfort, confidence, belonging and bonding within a special community [18]. Meanwhile, RVTS supervisors and medical educators hold responsibility for consistently supporting trainee learning and bridging any gaps in their knowledge so that they can work in rural settings [18]. The Cultural Educators and Cultural Mentors Network equally provide 2 years of one-on-one cultural mentoring with a local First Nations community member to improve cultural safety.

3 | Implications of Trainee Selection for Longer-Term AMS Placements

The RVTS is a retention-focused program, so the RVTS leadership commented that the doctors selected for the AMS stream have shown a demonstrated commitment to training continuously in First Nations communities. The RVTS leadership team suggested that the model allows trainees to build longer-term relationships and trust with First Nations communities, aiding health-seeking behaviour centred on family and community. However, sourcing candidates already based in rural AMSs and who have these motivations can be challenging. To promote interest, the RVTS collaborates with the national body for Aboriginal Community Controlled Health Organisations (ACCHOs), its state affiliates and individual rural AMSs. Administrative data identified that the AMS stream has attracted variable numbers of applicants and eligible candidates since it has been in operation. Since 2021, applicant numbers have declined, with fewer eligible candidates available to fill the ten places offered annually, although the majority of those deemed eligible have continued to accept positions in the AMS stream.

The RVTS leadership team reflected that AMSs may prefer the selection of Australian General Practice Training Program (AGPT) candidates who are eligible for salary support, rather than recruiting doctors otherwise eligible for RVTS. Salary support funding adds to income generated for the AMS from a trainee's Medicare billings. The potential value of an RVTS trainee (not currently attracting salary support) for longer-term quality of care requires ongoing promotion within this market.

In 2018, to support AMS stream recruitment, the RVTS introduced a Targeted Recruitment Strategy (TRS) involving collaboration with other agencies and communities to attract non-vocational AMS doctors to the RVTS program [19]. Since 2021 the TRS has provided salary support for AMSs and the published evaluation results suggest that this has strengthened recruitment to the AMS stream with around 40% of TRS positions being filled by doctors working in AMS's [16, 19].

The RVTS leadership team also noted that the AMS stream participants have similar characteristics as doctors enrolled in the remote stream: median age, 40 versus 39 years, median clinical experience at RVTS enrolment, 14 versus 12 years, with fewer male doctors, 55% versus 67% although similar proportions of international medical graduates (IMGs), 76% versus 73% [16]. AMS posts have also been distributed nationally, although the leadership team reflected that there is a need to ensure that the distribution fits the relative population spread of First Nations people in New South Wales (21% compared with 34% population) whilst being over-represented in states like Queensland (38% compared with 29% respectively) and Victoria (25% compared with 8%). A large proportion of rural AMSs are centralised in larger regions/rural towns (i.e., MMM2-3) and the AMS stream distribution aligns with this (50% in MMM2) [23].

4 | Training Continuity, Progression and Implementation Lessons

The RVTS leadership team noted that as of November 2023, 36 of 71 AMS stream participants had completed GP fellowship after 3–4 years of practice-based training, with 14 participants still in training. The team considered that many AMS trainees enjoyed contributing to the health and well-being of First Nations communities. By staying in one AMS over 3–4 years, they felt that trainees could gain exposure to preventative health across a spectrum of issues, contributing to holistic and multidisciplinary team-based care and quality improvement.

Published results from the evaluation identified that as of 2023, 21/57 (37%) doctors enrolled in the AMS stream withdrew from the RVTS, compared with 67/348 (19%) in the remote stream (significantly higher withdrawal rate for AMS) [17]. The RVTS leadership team reflected that the two main reasons for withdrawal were similar to the remote stream, being non-progression and relocation to non-eligible locations. Staff noted that non-progression could be influenced by the earlier rounds of the AMS stream not selecting the most suitable candidates, when the selection process was still being refined. The RVTS

team also observed that half of the withdrawals in the AMS stream also occur after the third year of training, compared with withdrawals occurring earlier in the remote stream. This period is commonly a point when non-progression is confirmed. Finally, after several years working in AMSs, it was considered that trainees may want a different experience to support their preparation for fellowship assessment. Positively, most who withdrew had already provided around 3 years of service to First Nations communities.

Employment conditions (not within the RVTS' control) could also play a role in leaving the AMS. The RVTS leadership reflected that involving trainees in service quality improvement projects, particularly those contemplating leaving their medical service, could improve their retention by honing the focus on bigger picture issues that make a lasting difference to First Nations communities. Further, they noted that it is critical for trainees to receive a strong induction and supervisor-facilitated early conversations with the AMS to set expectations for trainee doctors within AMSs and to establish pathways to resolve issues.

5 | Continuity, Retention and Perceived Community Benefit

Published results from the evaluation showed that the overall performance of the RVTS cohorts regarding satisfaction, service continuity and longer-term retention is encouraging [17, 24]. Of 36 doctors completing the AMS stream by November 2023, four out of five (80%) remained in the same rural community for up to 2 years post-program, and more than a quarter remained in their AMS up to 7 years post completion of training [17, 21]. Published evaluation findings also highlight participants' and stakeholders' reflections on the community benefits of training in the same location for 3–4 years [20].

6 | Policy and Program Implications

Although the AMS stream of the RVTS program is small relative to overall GP/RG training numbers, this commentary provides evidence that it has maintained a stable cohort of trainees based in AMS settings for 3–4 years over a 10-year period. Critically by preserving AMS training quotas, delivering a holistic supervision and support model focusing on retention, along with cultural education and mentorship, the RVTS has achieved reasonable continuity of AMS participants and produced longer-term retention of GPs/RGs in First Nations communities. The wider sector could draw from these results and offer a quota of longer-term training places in AMSs to produce a workforce providing continuity of care for First Nations peoples.

Many GP/RG trainees outside of the RVTS may not be suitable for remote supervision but could still train longer-term in AMSs using a mix of face-to-face and online supervision and other innovative arrangements [25]. This commentary highlights that trainee suitability for this model is essential, including selecting trainees who are reflective and likely to thrive when working across a wide-ranging caseload within AMSs' team-based care models. The selection of suitable candidates is enabled when there are more applicants. However, effective planning and engagement of doctors in this model also relies on targeted data indicating where First Nations communities require longer-term GPs and how many eligible non-vocationally trained candidates are in AMSs that can be invited to apply for training. Aligning the availability of salary support with longer-term GP training opportunities in AMSs could also improve the uptake of longer-term GP/RG training in AMSs beyond RVTS' AMS stream.

The commentary further highlights that reducing turnover is important. Trainees and AMSs may require tailored orientation, clarity around role expectations, and effective troubleshooting processes. Supporting trainees to feel valued and resilient enough to continue is likely to require more than standard clinical supervision—extending to mentorship and career coaching [18]. Further, encouraging a service-learning culture across the national and state ACCHO affiliates and supporting GP training pathways to partner with AMSs around the goals of GP trainees could support the uptake of longer-term GP training in AMSs.

In summary, strengthening longer-term GP trainee training in rural AMSs is highly relevant to efforts to Close the Gap in First Nations healthcare. The RVTS, having enrolled 71 trainees in its AMS stream as of 2023, offers valuable insights to inform and continuously improve longer-term training in AMSs, ultimately benefiting First Nations communities. The program has also demonstrated that end-to-end vocational training in general practice in this setting is achievable.

Author Contributions

Patrick Giddings: conceptualization (equal), writing – original draft (equal), writing – review and editing (equal), project administration (lead). **Belinda O'Sullivan:** conceptualization (equal), writing – original draft (equal), writing – review and editing (equal), project administration (supporting). **Matthew McGrail:** conceptualization (supporting), writing – original draft (supporting), writing – review and editing (supporting). **Marlene Drysdale:** writing – review and editing (supporting). **David Baker:** writing – review and editing (supporting). **Veeraja Uppal:** writing – review and editing (supporting).

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Conflicts of Interest

The evaluation was funded by the RVTS through funds from the Australian Government Department of Health, Disability and Ageing. The funder was involved in the project reference group, but the researchers worked independently.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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