Policy Document

Clinical Placements and Remunerated Medical Student Positions (2023)

Position Statement

AMSA believes that:

1. All medical students should have access to clinical placements that are of high quality regarding academic education and student support.
2. Students should be well supported in terms of their safety, wellbeing, and quality of learning during clinical placements.
3. Barriers to quality clinical placements should be identified and appropriately addressed. These barriers include inadequate support, training, and resources for clinicians at teaching hospitals, as well as a lack of proper exposure, supervision, guidance, infrastructure and standardisation across teaching sites.
4. Clinical placements must be culturally safe for students, clinicians, and patients alike.
5. The mental health and wellbeing of students and staff requires increased prioritisation. Specifically, efforts should be made to improve the accessibility of clinical placements and promote inclusive teaching practices, to ensure that placements equitably equip students with the skills required to become successful clinicians.
6. Teaching clinicians must be equipped with the skills and training to engage students in meaningful and culturally safe learning experiences, with a particular focus on Aboriginal and Torres Strait Islander health practices.
7. Students who have achieved the graduate competencies outlined by the Australian Medical Council should have access to remuneration via Assistants in Medicine positions that operate within the constraints of the clinical placement, supporting students financially without compromising on time or quality of education during placement.

Policy Points

AMSA calls upon:

1. All Australian medical schools and clinical schools to:
    a. Strive to develop and ensure all students are provided high quality clinical placements;
    b. Ensure clinical teaching, tutorials, and educational resources provided to medical students on clinical placement are inclusive, intersectional,

Head Office
A Level 1,
39 Brisbane Avenue,
Barton, ACT 2600

Postal Address
PO Box 6099,
Kingston, ACT 2604

ABN:
67079 544 513

Email:
info@amsa.org.au

Website:
www.amsa.org.au

culturally safe, and free from racist, classist, sexist, homophobic, transphobic, and intersexist rhetoric;

c. Develop a clinical curriculum which is cognisant of health inequities perpetuated by systemic marginalisation;
d. Ensure education providers develop LGBTQIASB+ friendly environments and curriculum to allow for anti-oppressive teaching to develop, to tackle existing societal heterosexist and heteronormative assumptions;
e. Ensure clinical cases and question prompts include patients where sexual orientation and/or gender identity is unrelated to the competency or pathology being assessed;
f. Provide the opportunities for students to meaningfully interact with Aboriginal and Torres Strait Islander communities and patients, and learn how to provide culturally safe care;
g. Provide students with a wide breadth of learning opportunities, including but not limited to:
    i. Exposure across a variety of specialties/subspecialities;
    ii. Exposure to a variety of settings - tertiary hospital centre and rural placements, and hospital and community-based placements;
h. Commit to upholding a high standard of teaching when learning must be delivered online. This includes:
    i. Ensuring accessibility for all;
    ii. Developing learning resources specifically tailored to online delivery;
    iii. Utilising online learning as a supplement not substitution for placement-based education;
i. Provide clinical educators with standardised, clearly defined expectations of learning objectives including but not limited to teaching aims, expected academic outcomes, time commitments, and availability requirements;
j. Initiate training of medical students as educators early in their course, as to produce a workforce of junior doctors prepared to educate future generations of medical students;
k. Provide a safe platform for medical students to offer anonymous feedback regarding strengths, weaknesses and areas of improvement of clinical placements. Facilitate and encourage a placement culture that values growth and improvement via prioritisation of transparent and confidential feedback processes;
l. Ensure the safety and protect the wellbeing of students as they progress through their education in the hospitals and community;
m. Provide meaningful and easily accessible mental health support to all students who need it;
n. Guarantee that accessing any provided mental health support will not detrimentally affect involvement with clinical placement programs or assessment outcomes;

o. Provide consideration and support regarding the financial burdens of housing and commuting costs (fuel, parking, public transport, time, etc.) incurred as an unavoidable component of clinical placement, especially regarding rural electives and placements;
p. Work collaboratively with hospitals employing medical students in remunerated positions to explore the impacts of these positions on medical student wellbeing and education.

2. Clinical sites and clinical teachers to:
    a. Increase teaching capacity by improving teacher to medical student ratios;
    b. Adequately protect in-person teaching time and patient contact, so students can sufficiently develop essential clinical and communication skills in hospital and community settings;
    c. Increase research into adequate clinician-to-student ratios that ensures individualised learning opportunities and promotes professionalism;
    d. Guarantee that clinical sites are culturally safe environments for Aboriginal and Torres Strait Islander medical students and that clinical teachers have undergone culturally safety training;
    e. Ensure adequate and standardised training of clinical teachers in becoming:
        i. the information provider;
        ii. the role model;
        iii. the facilitator;
        iv. the assessor;
        v. the curriculum and course planner;
        vi. the resource material creator;
    f. Ensure provision of training for clinical teachers is taking place in clinical settings with adequate incentives to improve comprehension and use of learned materials, with an effort made in recruitment of clinical experts to teach the areas of medicine related to their specific lived experiences;
    g. Streamline occupational health and safety requirements which disproportionately affect students from interstate, rural and remote, and international backgrounds;
    h. Ensure students are equipped with:
        i. Easily accessible resources to escalate cases of bullying, isolation, sexual harassment, and discrimination which protect victims from physical, psychological, or academic retaliation.
        ii. Bystander and first responder training to enable medical students to better advocate for their patients, colleagues and fellow students at all levels of seniority.

3. Medical students to:
    a. Provide high quality, constructive feedback to highlight areas of weakness and guide ongoing improvement of clinical placement;

b. Provide high quality, constructive feedback on the roles of remunerated medical students to inform future policy development and advocacy initiatives of student representation bodies;
c. Ensure clinicians feel valued in their teaching positions.

4. The Australian Medical Council to:
    a. Set standards for medical school assessment and accreditation which require demonstration of LGBTQIASB+ health competency;
    b. Ensure appropriate quality control and implementation of the AMC guidelines which outline Aboriginal and Torres Strait Islander health teaching standards in medical schools;
    c. Conduct research across Australian universities and clinical schools into:
        i. Whether equity is being achieved in delivering high quality clinical placements between all medical schools, and clinical sites affiliated with each medical school;
        ii. Current factors that pose barriers to achieving high quality clinical placement;
    d. Create guidelines, protecting in-person, patient-centred learning opportunities over online teaching whenever applicable. Implement policies that ensure student expectations are met, and graduates enter the workforce with adequate communication and procedural skills.
    e. Ensure access and exposure to all medical procedures outlined in state legislation via preferably on-floor, or if unfeasible, via simulated experiences, such as regarding termination of pregnancy.
5. Federal, State and Territory governments to:
    a. Facilitate the national coordination and implementation of Remunerated Medical Student Positions for clinical medical students that:
        i. Enables medical students to be given access to fairly remunerated roles without compromising on time or quality of clinical placement education;
        ii. Clearly defines the tasks able to be completed by students in remunerated positions to outline an appropriate scope of practice for medical students;
        iii. Are adapted and expanded in the context of a post-pandemic healthcare environment from their initial implementation as a surge workforce response to COVID;
        iv. Acts as an adjunct to the existing roles undertaken by interns and junior doctors as opposed to a replacement;
        v. Includes an employment contract with access to indemnity insurance and full workplace protections;
        vi. Involves clearly defined escalation and support pathways;
        vii. Incorporates proactive mental health support structures;
    b. Conduct research into the role of Remunerated Medical Student Positions in the healthcare system including but not limited to:
        i. Scope of practice;

ii. Working hours and conditions;
iii. Impact on clinical placement and medical education commitments;
iv. Wellbeing stressors of the balance of employment, education and personal factors;
v. Methods of improving the functionality of Remunerated Medical Student Positions and easing their transition into medical internship roles including but not limited to:
    1. Mandatory training of those in Remunerated Medical Student Positions;
    2. Improved access to electronic medical records and its functionality within the scope of the Remunerated Medical Student role;

c. Make recommendations and implement changes to Remunerated Medical Student Programs based on the outcomes of research detailed in the above point;
d. Eliminate discrepancies in teaching standards between medical schools by increasing funding to improve infrastructure and teaching capability in underfunded universities and clinical schools;
e. Fund supports towards anonymous reporting mechanisms and counselling services to support medical students experiencing bullying, isolation, sexual harassment, and discrimination on clinical placement.

Background

Clinical placement provides medical students with the practical experience fundamental to entering the medical workforce. Consolidation of preclinical learning during clinical placement enhances learning outcomes and overall student satisfaction in terms of social, academic and individual wellbeing. Feedback from medical students has also reflected that quality clinical placements have been helpful in guiding their development of analytical clinical skills, facilitating patient interaction and providing real-life examples of academic concepts.[1]

This policy will explore quality clinical placements through two lenses; academic quality and student safety and wellbeing.

Academic Quality of Clinical Placements

Teaching Capacity of Clinicians

There is limited literature exploring the teaching capacity of doctors and optimal ratios for medical student clinical education. Little published data exists, especially in the Australian context of student to staff ratios, both ideal and realistic. One publication on teaching suturing skills in 2006 highlighted an optimal ratio of 1 clinician to 4 students.[2] Distorted ratios negatively impact student learning

experiences, with fewer individualised learning opportunities. Altered clinician to student ratios, for example in resource-deprived environments, can therefore be challenging environments to develop professional skills.[3]

The literature does, however, highlight the importance of students developing clinical skills and competencies with complexity associated with physician lead teaching and communication.[4]

Anecdotally, the number of students on a medical team has continued to increase within Australia. This issue has been exacerbated in the post-COVID era, where staff are moved between wards to mitigate workforce shortages. There is literature documenting that COVID-associated reductions in placement time and clinical opportunities are associated with in a personal lack of confidence in students' own skills, stemming from reduced patient exposure and physician clinical teaching time.[5]

Upskilling Medical Practitioners

The modern medical practitioner inhabits an amalgam of roles. One of a physician's key responsibilities is to be an effective educator. Six major educational roles for physicians have been identified,[6] including:

1. the information provider;
2. the role model;
3. the facilitator;
4. the assessor;
5. the curriculum and course planner; and
6. the resource material creator.

Although healthcare practitioners have the medical knowledge required to teach medical students, they rarely have the teaching skills required to educate adequately. This gap between clinicians' medical knowledge and ability to share this information compromises students' quality of education and overall learning experience.[7]

Several initiatives have been proposed to improve the quality of clinician-led education. One key idea is that the behaviour and performance of clinical teachers can by improved by empowering them with self-efficacy.[8] Namely, efforts should be made to improve teachers' content knowledge and provide clinical teachers with all the resources they need to effectively teach.[9] These resources can include training workshops, constructive evaluation and feedback sessions, interactive sessions with experts focused on learning basic teaching skills, and extensive access to literature on teaching.[10]

Clinician participation in training initiatives has been disappointingly low, with poor attendance and inadequate learning transfer, even in institutions that prioritise the allocation of resources towards teaching. One potential solution is to host these training sessions during the clinical workplace's working hours, with adequate compensation for the clinician's time. Such an intervention could potentially improve compliance and incentivise a higher level of comprehension of the material.[11] Improving clinical teachers' connection to their students and fellow faculty, in conjunction with a promoting sense of feeling valued, has also been shown to improve the retention and quality of clinical teachers.[12]

Another important group requiring training on effective education is medical students themselves. Early instruction on how to be an effective educator ensures that teaching is part of emerging junior doctors' professional identity. This could include providing opportunities for peer instruction, or sessions about teaching skills and communication in a university and clinical setting. Such instruction improves students' knowledge of the content, and also provides the prerequisite skills required to educate patients, trainees, and colleagues as required during their future careers. Early medical student education on education skills thereby improves quality of care, and raises quality of education for future medical students on clinical placements.[13]

Inclusive teaching practices

The heteronormativity, cisnormativity and allonormativity of medical education has been a long-standing issue with the curriculum. This normativity is reflected by the fact that LGBTQIASB+ patients are often only written into stereotypical pathological scenarios.[14] For instance, as opposed to presenting a patient from the LGBTQIASB+ community with symptoms of a stroke, such patients are more likely will be connected to a case on sexually transmitted infections or reproductive health concerns. The Tufts Biomedical Queer Alliance recommends that clinical cases and question prompts include patients where sexual orientation and/or gender identity is unrelated to the competency or pathology being assessed [15].

The current Australian Medical Council standards for assessment and accreditation, which influences graduate outcomes through clinical time, has no specific LGBTQIASB+ teaching nor standardisation. Unfortunately, the deconstruction of these binary norms and push for degendering teaching has not been successfully achieved.[16]

The body of literature on degendering teaching in medical education is not extensive, particularly in the context of sexual and reproductive health.[17] Exclusionary and/or marginalising teaching in the prevocational years may perpetuate this issue, thus negatively impacting patient outcomes.

Previously literature has proposed this can be achieved through medical education that focuses on open and inclusive language for history taking, education on identity language and teaching the social determinants of health that impacts patient outcomes. Into clinical years, screening, counselling, interventions for different population groups including transgender care should be a priority of education with reflecting on clinical practices.[15]

Student exposure to quality training of inclusive and affirmative LGBTQIASB+ health delivery will potential reduce the inequality in healthcare access and outcomes.[18] The provision of high quality, anti-oppressive teaching regarding LGBTQIASB+ health is therefore of vital importance.

Anti-oppressive teaching styles encompasses a commitment to change curriculum, pedagogy, and culture to move away from traditional education methods that contribute to oppression of minority groups in society.[19] It has been previously explored in nursing and social work for gender and sexual minorities where beliefs and attitudes of heterosexual healthcare workers were developed to be more self-aware of their attitudes that impact their practice [20]. Activism in the form of calling out structural inequalities to influence education was also a component. In healthcare, the opportunities for workers to disclose aspect of their understanding of sexual and gender identities and formulate discussions on how this impacts healthcare delivery, needs to be integrated into training. [20] The literature in this field encourages education providers to develop LGBTQIASB+ friendly environments and curriculum to allow for anti-oppressive teaching to develop, to tackle existing societal heterosexist and heteronormative assumptions.[20]

Online and Distance Learning

Clinical placements were suspended and the medicine curriculum was delivered virtually during the COVID-19 epidemic.[21] This period of disruption gave rise to a “medical education revolution”, characterised by a shift towards online content delivery.[22] Many students are very concerned about the mostly unnecessary continuation of online placements over traditional in-person learning opportunities. There is a lack of data on the proportion of placements currently being delivered online. There is also a lack of explicit rules governing exactly what an online clinical placement should entail. There is therefore no universal application of any rules, regulation or guidelines regarding online and distance learning in medical school.

Some literature suggests that online placements should ideally be similar to a problem-based learning (PBL) class.[23] Specifically, the literature asserts that online clinical placements should ideally involve the student independently reviewing the patient's history, physical exam findings, investigation and management plan, before discussing the case via Webinar with a clinician [23]. There are pros and cons to such a teaching approach.

There are some potential benefits to delivering clinical placements online. The primary advantages of delivering student placements virtually include improved accessibility and engagement,[22] a mitigated risk of students experiencing trauma on placement,[24] exposure to telehealth,[25, 26] and the opportunity to practise procedures online before working with real patients.[27] One systematic review even suggested that eLearning was possibly superior to traditional learning in terms of knowledge and clinical reasoning skill development.[28] However, this systematic review neglected to examine whether eLearning results in equivalent development of other vital clinical skills, including communication skills and procedural skills.

Medical student learning outcomes following virtual placements were extensively documented in the literature during the pandemic.[21] Concerningly, students expressed lower overall confidence in their communication skills and clinical skills following online placements. This lower confidence was attributed to having limited opportunities to practise their procedural skills, including physical examination skills.[22] Additionally, students had limited opportunities to develop their communication skills via interaction with patients and other members of the healthcare team during online placements.[23, 29] Students' lower confidence translated to higher overall anxiety about transitioning to clinical practice.[30]

Students also missed out on other important aspects of medical education during online clinical placements. Namely, many students reported receiving a low quality of education due to technical issues and limited communication from staff.[22, 30] It was also more difficult for students to build strong relationships with supervisors online. Hence, many students missed out on important opportunities for feedback, reflection and mentoring.[31] Such experiences are important for the development of a professional identity and sense of intra-discipline inclusivity.[32] Numerous students also struggled to remain engaged with the content, establish work-life boundaries, maintain relationships and prevent burnout due to physical separation from their peers and learning environment during online placement.[22, 33] It was also difficult to develop a meaningful partnership with the community whilst studying online,[34] thus affecting the likelihood of rural workforce retention [35], as well as interest in general practice and community care.[36] The literature suggests

that “supported participation” is critical for clinical workplace learning [37], and that online placements are unlikely to significantly reduce university costs or fees.[22]

In summary, online clinical placements are continuing for some students despite such a measure being no longer necessary. Whilst an online format does improve the accessibility of clinical placements, and may be appropriate for purely academic content, the literature suggests that students lose many vital learning opportunities when forced online. Many students are concerned about what the continuation of online placements means for their learning and later quality of clinical practice.

Standard Setting between Universities

The Australian Medical Council (AMC) is an independent national body, responsible for setting the standards of medical education across Australia.[38] The AMC is also responsible for standardising graduate outcomes. Clinical placements aim to sufficiently prepare students to achieve the AMC’s graduate outcomes, via supported participation in teaching activities and assessments, as outlined in AMSA’s Graduate Outcomes and Assessment policy.[39] Equalising each university’s degree of access to quality teaching and resources, as well as a breadth of experience, is critical given the central role of clinical placements in student learning.

The ‘experience based learning’ model suggests students exposed to a greater range of situations, with appropriate support and assistance when placed in situations beyond their comfort zone, are better prepared and safer clinicians when entering the workforce.[40] This idea is backed by data associating participation in a greater diversity of clinical settings with increased medical student confidence.[41] Standardising clinical placements to provide all students exposure to this breadth of teaching is necessary to optimise preparation of the next generation of medical professionals.

Student satisfaction differs between Australian universities.[42] However, there is limited literature on the source of these inequalities in student satisfaction within the Australian clinical placement context. Anecdotally, clinical schools often differ in the quality of student support and organisation. Clinical schools also often differ in the level of engagement of clinical educators and number of opportunities for meaningful feedback.

One reason that universities may struggle to equalise their quality of clinical placements and teaching in general is the lack of explicit standards. Namely, learning requirements, expectations and aims can sometimes be very unclear.[43] Effectively-communicated, clearly-defined expectations of clinical educators,

standardised across all clinical schools and universities would be beneficial in ensuring equality in medical student experience.

Providing students with the opportunity to vocalise feedback on clinical placement is an important part of fostering ongoing improvement of medical education and ensuring a high-quality placement.[44] One study found that in addition to quantitative feedback, qualitative feedback from students regarding clinical placement gave useful insight into areas where students felt the educational environment was not meeting their needs. This feedback could then be translated into actions that improved the education environment and more broadly the quality of education in general.

Student Safety and Wellbeing

Mental Health

Medical students are at a higher risk of mental illness and suicide than the general population.[45] Many factors can affect the wellbeing of a student on clinical placement including but not limited to bullying, harassment, isolation, academic stressors, and the stigma surrounding mental illness. This is explored in greater detail in AMSA's Mental Health and Wellbeing policy.[46] An intersectional perspective is important to consider when evaluating student wellbeing on clinical placement as a multitude of factors such as gender, age, race and sexual orientation have shown to affect individual clinical learning experiences. Studies have shown that female medical students are at a higher risk of suicide compared to males.[45] Medical students who identify as LGBTIQASB+ experience a greater risk of depression and anxiety due to the homophobia, transphobia, and intersexism experienced within a heteronormative educational environment.[47]

A large proportion of medical students come from religious and cultural minority groups in Australia. Despite being a culturally and linguistically diverse nation, Australian medical students from minority groups face marginalisation, discrimination, and racism. It is important to understand that racism in the clinical environment is not just confined to racist comments or active discrimination. Systemic and structural racism is still prevalent in the hospital setting and hinders access to employment opportunities for many students. Discriminatory comments on student performance negatively impact learning experiences and deter students from seeking clarification or asking for help.[48] Due to this ingrained systemic racism, students from minority groups often refrain from speaking up due to the fear that it may detrimentally affect their clinical placement assessments and learning opportunities.

A multifactorial approach must be taken to address these factors and improve the quality of clinical placements, including LGBTIQASB+ and minority inclusion training for all medical practitioners and hospital teaching staff, and readily accessible support services for all students.

Bullying, Isolation and Sexual harassment

Although all universities have policies in place for bullying and harassment, relevant policies often do not cover off campus learning sites, such as clinical placement. Hospitals also have policies available for bullying and harassment, but students are often not aware of these policies due to limited accessibility and awareness. Thus, medical students experiencing bullying and harassment may feel isolated and confused regarding where to seek help.

The prevalence of bullying and harassment in the clinical environment is high. Within 8 months of commencing placement, 20% medical students reported that they experienced or witnessed bullying and harassment. Additionally, by the end of their medical education, 60% of medical students reported to have been exposed to bullying and harassment in the clinical environment.[49] Medical students identifying as LGBTIQASB+ reported higher levels of bullying and mistreatment, with 43% stating that they had experienced an episode of mistreatment at some point during medical school.[50] The prevalent hierarchical structure of the hospital environment increases the instances of bullying and harassment due to power imbalances that are often abused. To combat this issue and prevent further instances of bullying, mistreatment and harassment in the workplace, teaching hospitals should ensure security staff are trained to assess and appropriately manage acts of bullying and aggression between staff and students. This is discussed further in AMSA's Bullying and Harassment in Medicine policy [51] and Sexual Harassment policy [52].

Although there are selection adjustments available for students of Aboriginal and Torres Strait Islander origin and people from low socioeconomic status (SES), the medical admissions process greatly favours students from higher SES backgrounds.[53] Students from low SES and Aboriginal and Torres Strait Islander backgrounds are therefore more likely to experience feelings of isolation. Such feelings have detrimental effects on these students' mental wellbeing, which in turn affects their academic performance, leading to higher attrition rates. The accessibility to Aboriginal Hospital Liaison Officers and other support services such as mentoring needs to be improved, as to maximise clinical learning experiences for Aboriginal and Torres Strait Islander students. Low SES students should also be supported throughout clinical placement through bursaries and scholarships as well as support services that promote inclusivity and decrease stress levels.

Meeting Occupational Health and Safety Requirements

Medical students cannot go on clinical placement without meeting relevant occupational health and safety requirements. Such rules are necessary to protect the health of patients and staff alike. Most medical schools outline occupational health and safety requirements relatively clearly. Medical students that do not meet these occupational health and safety requirements are therefore issued breach notices and have notes made on their academic record for noncompliance.

Students from rural, remote, interstate and international experience a disproportionate amount of stress in meeting occupational health and safety requirements. For instance, students cannot apply for a Queensland Blue Card without first being issued a customer reference number (CRN) from the Department of Transport and Main Roads (TMR).[54] However, students must either have a Queensland drivers licence or proof of Queensland address to be eligible for a TMR CRN.[55] Remote application options also mandate proof of local address.[56] Students that have only recently moved to their medical school, and may not have a permanent address yet, are therefore particularly vulnerable to issues in meeting this requirement. The Blue Card itself also requires an extensive wait time, and physical reception via post. Rather than accepting the nationally-recognised Working with Children Check, which has a much more streamlined application process, Queensland Health continues mandating reception of a physical copy of the Blue Card before placement commences.

Overall, it is important to ensure that more realistically achievable alternative occupational health and safety requirements are considered by state bodies, as to minimise the disproportionate amount of stress currently experienced by rural, remote, interstate and international students in meeting occupational health and safety requirements.

Workload and Exhaustion

Due to the high workload and academic rigour of the medical curriculum, levels of burnout and emotional exhaustion are high amongst medical students. This issue is exacerbated during clinical years, wherein many students struggle to balance placement with work, extracurriculars, personal life and academic workload. Medical students who are parents or primary carers face added difficulty in managing their academic and personal responsibilities. The lack of accessibility to childcare facilities in hospital settings is a major barrier affecting the quality of clinical placement for students with children as they often miss learning opportunities on placement whilst caring for their children.[57] Further information regarding medical students with dependents is provided in AMSA's Medical Students with Dependents policy.[58]

Cultural Safety on Clinical Placement

Culturally safe environments are spaces where personal identity and culture can stand free from assault.[59] There are several factors that make an environment or interaction culturally safe, including practice of cultural humility, resisting hierarchical approaches to concepts which challenge us, and engaging in deep reflection on one's own cultural background.[60, 61] Furthermore, cultural safety involves acknowledgement and active work to combat the interpersonal and systemic power imbalances that disempower people from minority backgrounds.[62]

Cultural safety is vital in ensuring that all stakeholders within the healthcare system feel accepted. Clinical placements must be environments where Aboriginal and Torres Strait Islander medical students are able to exist and excel within culturally safe frameworks. The definition of cultural safety for Aboriginal and Torres Strait Islander medical students may encompass (but not limited to) an inclusive clinical environment where staff and students are educated about local cultural practices, and students feel safe to voice their views and concerns as well as express their cultural identity without fear of judgement or discrimination. The valuable cultural knowledge brought into practice by Aboriginal and Torres Strait Islander medical students creates safer environments for Aboriginal and Torres Strait Islander patients. Models and frameworks to enable Indigenous students to escalate their concerts regarding culturally unsafe environments must be established and regularly reviewed to provide a platform to advocate for ongoing improvement. Culturally safe environments are more conducive to meaningful collaboration, wherein a diversity of perspectives can inform the healthcare decision making process. The literature asserts that Australia's current standards are not sufficient to ensure cultural safety within the healthcare system.[63] Listening to Aboriginal and Torres Strait Islander experts speak to how cultural safety can be most effectively promoted within the Australian healthcare system is of paramount importance to ensure equitable outcomes for Aboriginal and Torres Strait Islander people, both as clinicians and as patients.[64]

To develop meaningful relationships between healthcare professionals and Aboriginal and Torres Strait Islander communities, a culturally inclusive and safe environment must be fostered.[65] People identifying as Aboriginal or Torres Strait Islander reported fear of discrimination, racism, disrespect and judgement as intrinsic barriers to seeking healthcare amongst various other barriers including lack of accessibility to doctors of Aboriginal or Torres Strait Islander origin and Indigenous healthcare practices. Fear of government involvement was also reported, especially in regards to seeking medical treatment for children due to perceived judgement of bad parenting.[66] These factors are deeply rooted within

the community and must be addressed to promote meaningful relationships between the health service and the community. Using appropriate communication pathways and working with Aboriginal Health Workers, demonstrating commitment to building long standing relationships with community, and engaging in intentional reflexivity are all key activities which clinical sites and clinical teachers must promote and model to medical students to create culturally safe and meaningful clinical placements. Since a large proportion of medical students in Australia are international students, it is important to ensure adequate information regarding Australian history and appropriate training and exposure to local Aboriginal and Torres Strait Islander practices are provided during clinical placement so all students are equipped with the required skills to provide a culturally safe environment to patients from Aboriginal and Torres Strait Islander backgrounds. In particular this should include location-specific education regarding the practices and history of differing regions to address the immense diversity among Indigenous culture that exists across Australia.

Furthermore, it is important to note that the definition of 'good health' varies between cultural and religious communities. For Aboriginal and Torres Strait Islander people, good health is a holistic concept encompassing social, emotional, physical and spiritual well being. Connection to land, culture, ancestry and spirituality is a crucial component of Aboriginal and Torres Strait Islander wellbeing. Good health is achieved when the wellbeing of all members of the community is ensured.[67] The significance of Indigenous healthcare practices, cultural safety and doctors of Aboriginal and Torres Strait Islander origin is further explored in AMSA's Aboriginal and Torres Strait Islander Health policy.[68]

The Australian Medical Council is undertaking a review of standards for primary medical education at time of writing. There are substantial proposed changes to graduate outcome standards which foreground elements of cultural safety knowledge and practices.[69] These changes follow a lengthy consultation process which heavily involved the AMC Aboriginal and Torres Strait Islander and Māori Standing Committee and Aboriginal, Torres Strait Islander, and Māori stakeholders from medical schools around the country. Ongoing quality control and improvement will be essential in the successful implementation of the newly developed standard.

Location and Accessibility

Medical Universities provide minimal to no support in funding the transportation and housing costs incurred as an unavoidable component of clinical placement. Clinical placements are therefore difficult to access for many students undergoing their clinical years. There is no literature discussing this topic from the perspective of the experiences of current medical students. Ultimately, these issues have a significant impact on the safety and wellbeing of students.

Commuting

A prevalent issue for students is the commute time to clinical placement. Travel times can be substantial, often over an hour each way. Losing so much time to travel can be incredibly detrimental to students, as the cost of such a journey can be financially stressful. Furthermore, students often leave placement mentally and physically exhausted. Students often thereafter drive home fatigued, and therefore at risk of being involved in a road traffic accident or developing a mental health issue.[70] Reducing time to placement is an important means of preventing harm to students. Students with extensive travel times often struggle with studying enough to meet the academic expectations of the faculty, due to exhaustion upon arriving home coupled with the need to appropriately take care of themselves, work and uphold other social responsibilities. Providing students with the resources necessary to reduce the amount of time it takes for them to travel to and from placement could potentially help students have more time to prioritise their physical, mental and social well being as required to meet their faculty's academic expectations. This issue is further exacerbated with the current rental crisis in Australia. Due to how competitive the rental market is in regards to rent price and availability, students are left with no other choice but to find housing even further away from clinical locations. Providing means of housing support, particularly in metropolitan centres where this is not the norm, would also significantly assist in reducing commuting time and concerns.[71]

Financial Stressors

A predominant point of contention is the financial cost of accessing clinical placement, especially following the recent significant rise of fuel costs and public transport fees in some Australian states. A substantial component of this stress is the cost of parking. Free parking, concessional rates and onsite parking availability differ between sites. The maximum rates for public hospital onsite parking can range from roughly $30-50 per day.[72, 73] With stringent clinical placement attendance requirements, these costs accrue to become a significant point of financial burden on students. Some students have reported skipping meals or forfeiting social and physical activities as a means to afford to participate in placement. These sacrifices can place undue stress and pressure on medical students, ultimately harming their wellbeing. Providing financial support, such as travel allowances, grants and other financial incentives, to all students in need, including those in metropolitan areas, can improve mental health and educational outcomes.[71]

Safety Concerns

Many students that drive to placement may opt to park substantial distances from their clinical site in an effort to find cheaper or even simply available parking. However, walking a long way to their car in the evening can put students, especially

female-presenting students, in danger of being a victim of a crime. Safety is also a point of concern for students who use public transport. They may have to not only travel to reach, but also wait alone in the dark for buses, trains and trams, sometimes in unsafe areas. These safety concerns disproportionately affect students from low socioeconomic backgrounds. A reasonable means to overcome this, includes providing students access to staff-parking, as opposed to paying visitor's rates. Additionally, minimising transport at unsafe times for students taking public transport.

Remunerated Medical Student Positions

Introduction to the Assistant in Medicine Program:

The Assistant in Medicine (AiM) position is a new, paid role for medical students. The role was originally established as part of the surge workforce management response, with the aim of easing COVID-related staff shortages.[74] While similar assistantships have been adopted internationally, this program is new in Australia. This scheme could potentially alleviate the aforementioned issues in medical student financial stress during placement. Many students have found the support provided by the Students in Medicine (SiM) position invaluable as it assists students experiencing economic precarity to engage fully with pre-vocational learning.[75] Broader uptake of such a program should support students, without compromising their time or quality of education on clinical placement.

Current Remunerated Roles

Clinical placement schedules can be unpredictable, rendering it difficult for medical students to find consistent work and meet their living expenses. As such, innovative models of training that remunerate senior year students for their labour, within the limits of the healthcare system infrastructure, may improve students' ability to fully participate in clinical placement. The current AiM program provides a model to cater for medical students' needs, as standardised by the Australian Medical Council regarding final examinations.

Currently, New South Wales, Queensland and Victorian-based final-year medical students, attending an Australian Medical Council-accredited university, are eligible for participation in this scheme. Queensland-based medical students are also eligible to apply for the program in their penultimate year of medical school (Bond University, Griffith University and the University of Queensland) or the final three years of their degree (James Cook University). The tasks performed by AiMs vary between states. In Queensland, SiMs are responsible for clinical support through ward duties, scribe services, surgical assisting under supervision, improving productivity and clinical service continuity where applicable. Final year medical

students may additionally perform tasks including patient monitoring and observations, vital sign measurements and escalation of patients as per hospital and health services protocol.[76]

The AiM role was established as an opt-in position, for final year medical students in NSW, receiving 75% of NSW Medical Intern Salary. For Queensland, individuals who are employed by Queensland Health in the role of SiM in 2023, will be remunerated at a base rate equivalent to 80% of an Intern Level 1 outlined in the Medical Officers' (Queensland Health) Certified Agreement.[76] Additionally, the hours of work varied from 8 hours - 36 hours with the majority of AiM's (42%) contracted to work 32 hours per week (four days per week).

Benefits of Remunerated Medical Student Positions

Limited literature exists on the benefits and shortcomings of the current AiM program, since the role is so new within Australia. A review of the program initiated in 2021 has been commenced but remains incomplete.[77] There was also an evaluation report conducted by NSW Health.[75] This report found that the main tasks performed by AiMs included venepuncture, medical record documentation, cannulation, discharge summaries, scribing, and organising consults and investigations. This report also concluded that the AiM program improved students' confidence entering internship, by ensuring they developed the skills and capabilities required for safe patient care..[75] Furthermore, this report found that the AiM role improved the functioning of the medical team, as the AiM's lessened the junior medical officers' workloads and therefore allowed the junior medical officers to perform more tasks at the top of their scope of practice.

A benefit of introducing the AiM role in the pandemic response, is that non-healthcare setting employment was forgone for many students, allowing this paid employment role to alleviate financial stressors of unemployment.[75] Currently around half of medical students work during their degree, with many requiring paid work to continue their studies and maintain their lifestyle. In addition to this, the majority of working medical students reported issues with work impacting upon their studies. This illustrates a need for paid work that is flexible, allowing medical students to continue their studies without negative impacts upon their university work.[78] Currently, an AiM like role that has allowances for the adaptable schedule of senior medical students could fulfil this need. Likewise, a paid role in a healthcare team has been seen to raise clinical experience in a hands-on environment, helping not only the healthcare team, but also teaching invaluable clinical and teamwork skills to the students.[79]

Overall, existing literature suggests that the AiM role should continue to be offered when surge workforce requirements are demanded, and to improve transition to internship.

Limitations and Future Considerations for Remunerated Medical Student Positions

There is potential for AiM positions to negatively impact upon the quality and quantity of clinical placements via a decreased prioritisation of clinical education and expectation to work increased hours resulting in a compromise to student's work/study balance. Medical students have reported that while participation in the program has been valuable, students were at risk of missing out on important rotations, such as their emergency department rotation, in order to complete administrative tasks for their AiM role whilst on placement.[80] Strict guidelines and limitations are required to safeguard medical students from overwork and ensure protected time for clinical placement teaching.

As the role was developed in response to the pandemic crisis, ongoing communication allowed for the utilisation of AiM's with some timetable clashes occurring, which impacted upon students work/study balance [75]. In particular, reports of increased difficulty balancing studies and work when exams were during or directly after an AiM term. Queensland Health's Employment Directive for the SiM role in 2023 does prioritise the educational and wellbeing pillars of the employee, highlighting that rostering must be managed to avoid fatigue and honour the students medical school responsibilities and academic clinical placements. Students in these roles are encouraged to speak with their home institution for appropriate hours of work and to ensure completion of their degree is not compromised [75]. Future recommendations include discussion around medical school commitments and exam schedules for workforce rostering, as well as the impact of working terms on exams.

Additionally, The NSW Evaluation report outlined that the lack of understanding of the AiM role by the multidisciplinary team can be better understood with improved communication. The inability to prescribe medications is an evident limitation for AiMs to optimise team function. Given this, the NSW Health report recommended reconsidering this limitation when placing a student in this role on a team [75]. In addition, the unclear role of these AiMs could lead to confusions regarding scope of practice, resulting in students acting outside their scope which could have serious repercussions for both the patient and practitioner. Recommendations to mitigate these risks within the AiM positions include clear, standardised guidelines that clearly state the tasks able and unable to be performed by students in these roles.

As the implementation of this role in the Australian healthcare system was a result of the surge workforce requirement, the evidence for the benefit, limitations, and structure of the role, is yet to be explored. Following further literature defining the gold-standard framework for Assistants in Medicine, encompassing both the protection of their wellbeing and support of the healthcare system, AMSA will further clarify their position on this issue.

References

1. Diemers A.D., Dolmans D.H., Maarten G, Verwijnen M, Heineman E, Scherpbier A. "Students' opinions about the effects of preclinical patient contacts on their learning" 2008. Advances in Health Science Education. Vol. 13:633-4
2. Dubrowski A, MacRae H. Randomised, controlled study investigating the optimal instructor: student ratios for teaching suturing skills. Med Educ [Internet]. 2006 Jan [cited 2023 Feb 16]; 40(1):59-63. Available from doi: 10.1111/j.1365-2929.2005.02347.x
3. Gordon J. Abc Of Learning And Teaching In Medicine: One To One Teaching And Feedback. BMJ. 2003;326(7388):543–5.
4. O'Doherty D, Culhane A, O'Doherty J Harney S, Glynn L, McKeague H, Kelly D. Medical students and clinical placements - a qualitative study of the continuum of professional identity formation. Educ Prim Care [Internet]. 2020 Sep 11 [cited 2023 Feb 13]; 32(4). doi: 10.1080/14739879.2021.1879684.
5. Davis J. Two years of medical education during COVID-19 [Internet]. NSW: MJA; [2022 Jan 17; cited 2023 Feb 18]. Available from: https://insightplus.mja.com.au/2022/1/two-years-of-medical-education-during-covid-19/
6. Crosby RMH. Amee guide no 20: The good teacher is more than a lecturer - the twelve roles of the teacher. Med Teach. 2000;22(4):334–47.
7. Ramani S, Leinster S. AMEE Guide no. 34: teaching in the clinical environment, Medical Teacher, 30:4, 347-364, DOI: 10.1080/01421590802061613
8. Bourne MJ, Smeltzer SC, Kelly MM. Clinical teacher self-efficacy: A concept analysis. Nurse Educ Pract. 2021 Mar;52:103029. doi: 10.1016/j.nepr.2021.103029.
9. Swackhamer, L. E., Koellner, K., Basile, C., & Kimbrough, D. Increasing the Self-Efficacy of Inservice Teachers through Content Knowledge. TEQ, 36(2), 63–78. http://www.jstor.org/stable/23479252
10. Busari JO, Prince KJ, Scherpbier AJ, Van Der Vleuten CP, Essed GG. How residents perceive their teaching role in the clinical setting: a qualitative study. Med Teach. 2002 Jan;24(1):57-61. doi: 10.1080/00034980120103496.
11. Cantillon, P., D'Eath, M., De Grave, W. et al. How do clinicians become teachers? A communities of practice perspective. Adv in Health Sci Educ 21, 991–1008 (2016). https://doi.org/10.1007/s10459-016-9674-9
12. Wisener KM, Driessen EW, Cuncic C, Hesse CL, Eva KW. Incentives for clinical teachers: On why their complex influences should lead us to proceed with caution. Med Educ. 2021 May;55(5):614-624. doi: 10.1111/medu.14422
13. Meyer HS, Larsen K, Samuel A, et al. Teaching Medical Students How to Teach: A Scoping Review. Teach Learn Med. 2022;34(4):379-391. doi: 10.1080/10401334.2021.1979006
14. Murphy M. Hiding in Plain Sight: The Production of Heteronormativity in Medical Education. JCE [Internet]. 2014 Nov 6 [cited 2023 Feb 16]; 43(3). doi: 10.1177/0891241614556345.
15. Tufts Biomedical Queer Alliance. Recommendations for LGBTQ-Inclusive Content in Medical School Curricula [Internet]. Medford: Tufts University; 2018 [cited 2023 Mar

24]. 9 p. Available from: https://sites.tufts.edu/tuftsbqa/files/2016/04/BQA-Curriculum-Recs-2018.pdf
16. Halliwell F. LGBTQIA+SB content in medical education: what lies ahead? [Internet]. NSW: MJA; [2022 Sep 26; cited 2023 Feb 18]. Available from: https://insightplus.mja.com.au/2022/37/lgbtqiasb-content-in-medical-education-what-lies-ahead/
17. Alpert A, Manzano C, Ruddick R. Degendering Oncological Care and Other Recommendations to Eliminate Barriers to Care for Transgender People with Cancer [Internet]. Virginia: ASCO; [2021 Jan 19; cited 2023 Feb 17]. Available from: https://dailynews.ascopubs.org/do/degendering-oncologic-care-and-other-recommendations-eliminate-barriers-care
18. Rainbow Health Victoria. Research Matters: Why do we need LGBTIQ-inclusive services? [Internet]. Melbourne: La Trobe University; 2020 [cited 2023 Mar 24]. 7 p. Available from: https://www.rainbowhealthvic.org.au/media/pages/research-resources/research-matters-why-do-we-need-lgbtiq-inclusive-services/3898382955-1614819704/research-matters-lgbtq-inclusive-services.pdf
19. Kumashiro K. Against Common Sense: Teaching and Learning Toward Social Justice. Teach Teach Educ. [Internet]. 2008 May [cited 2023 Mar 24]; 24(4): 1112-1114. Available from: https://www.researchgate.net/publication/240432837_Kevin_K_Kumashiro_Against_Common_Sense_Teaching_and_Learning_Toward_Social_Justice_Routledge-Falmer_NY_2004_13000_Hardback_ISBN_9780415948562_ISBN10_0415948568_3395_Paperback_ISBN_9780415948579_ISBN10 Url DOI: 10.1016/j.tate.2007.07.001
20. Pack M, Brown P. Educating on anti-oppressive practice with gender and sexual minority elders: Nursing and social work perspectives. Aotearoa N. Z. Soc. Work. [Internet]. 2017 Jul [cited 2023 Mar 24]; 29(2), 108-118. Available from: https://www.researchgate.net/publication/318990768_Educating_on_anti-oppressive_practice_with_gender_and_sexual_minority_elders_Nursing_and_social_work_perspectives Url DOI: 10.11157/anzswj-vol29iss2id279
21. Hickland MM, Gosney ER, Hare KL. Medical student views on returning to clinical placement after months of online learning as a result of the COVID-19 pandemic. Medical Education Online. 2020 Jan 1;25(1):1800981.
22. Torda A. How COVID-19 has pushed us into a medical education revolution. Internal medicine journal. 2020 Sep;50(9):1150-3.
23. Sam AH, Millar KR, Lupton MG. Digital clinical placement for medical students in response to COVID-19. Academic Medicine. 2020 Aug 1;95(8):1126.
24. Patel A, Underwood P, Nguyen HT, Vigants M. Safeguard or mollycoddle? An exploratory study describing potentially harmful incidents during medical student placements in Aboriginal communities in Central Australia. Medical journal of Australia. 2011 May;194(10):497-500.
25. Pit SW, Velovski S, Cockrell K, Bailey J. A qualitative exploration of medical students' placement experiences with telehealth during COVID-19 and recommendations to prepare our future medical workforce. BMC Medical Education. 2021 Dec;21(1):1-3.
26. Dost S, Hossain A, Shehab M, Abdelwahed A, Al-Nusair L. Perceptions of medical students towards online teaching during the COVID-19 pandemic: a national cross-sectional survey of 2721 UK medical students. BMJ open. 2020 Nov 1;10(11):e042378.

27. Graber MA, Wyatt C, Kasparek L, Xu Y. Does simulator training for medical students change patient opinions and attitudes toward medical student procedures in the emergency department?. Academic emergency medicine. 2005 Jul;12(7):635-9.
28. George PP, Papachristou N, Belisario JM, Wang W, Wark PA, Cotic Z, Rasmussen K, Sluiter R, Riboli–Sasco E, Car LT, Musulanov EM. Online eLearning for undergraduates in health professions: a systematic review of the impact on knowledge, skills, attitudes and satisfaction. Journal of global health. 2014 Jun;4(1).
29. Choi B, Jegatheeswaran L, Minocha A, Alhilani M, Nakhoul M, Mutengesa E. The impact of the COVID-19 pandemic on final year medical students in the United Kingdom: a national survey. BMC medical education. 2020 Dec;20(1):1-1.
30. Baticulon RE, Sy JJ, Alberto NR, Baron MB, Mabulay RE, Rizada LG, Tiu CJ, Clarion CA, Reyes JC. Barriers to online learning in the time of COVID-19: A national survey of medical students in the Philippines. Medical science educator. 2021 Apr;31:615-26.
31. Birden HH, Usherwood T. "They liked it if you said you cried": how medical students perceive the teaching of professionalism. Medical Journal of Australia. 2013 Sep;199(6):406-9.
32. Weaver R, Peters K, Koch J, Wilson I. 'Part of the team': professional identity and social exclusivity in medical students. Medical education. 2011 Dec;45(12):1220-9.
33. Sani I, Hamza Y, Chedid Y, Amalendran J, Hamza N. Understanding the consequences of COVID-19 on undergraduate medical education: Medical students' perspective. Annals of medicine and surgery. 2020 Oct 1;58:117-9.
34. Maurana CA, Beck B, Beversdorf SJ, Newton GL. Moving From Medical Student Placement to a Community-Academic Partnership With a Rural Community. The Journal of Rural Health. 2000 Sep;16(4):371-9.
35. Clark TR, Freedman SB, Croft AJ, Dalton HE, Luscombe GM, Brown AM, Tiller DJ, Frommer MS. Medical graduates becoming rural doctors: rural background versus extended rural placement. Medical Journal of Australia. 2013 Dec;199(11):779-82.
36. Howe A, Ives G. Does community-based experience alter career preference? New evidence from a prospective longitudinal cohort study of undergraduate medical students. Medical education. 2001 Apr 22;35(4):391-7.
37. Dornan T, Boshuizen H, King N, Scherpbier A. Experience-based learning: a model linking the processes and outcomes of medical students' workplace learning. Medical education. 2007 Jan;41(1):84-91
38. Australian Medical Council. The AMC purpose and constitution [Internet]. Available from: https://www.amc.org.au/about/about-2/about/
39. Australian Medical Students' Association. Graduate Outcomes and Assessment Policy [Internet]. Australian Medical Students' Association:2022 [cited 20 Feb 2023]. Available from: https://amsa.imiscloud.com/common/Uploaded%20files/AMSA/Policy/D/Graduate%20Outcomes%20and%20Assessment%20(2022).pdf
40. Dornan T, Conn R, Monaghan H, Kearney G, Gillespie H, Bennett D. Experience Based Learning (ExBL): Clinical teaching for the twenty-first century. Medical Teacher. 2019 Aug 6;41(10):1098–105.
41. McNair R, Griffiths L, Reid K, Sloan H. Medical students developing confidence and patient centredness in diverse clinical settings: a longitudinal survey study. BMC

Medical Education [Internet]. 2016 Jul 15;16(1). Available from: https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-016-0689-y

42. Top Medicine Universities in Australia [Internet]. Uni Reviews. 2015 [cited 2023 Feb 20]. Available from: https://universityreviews.com.au/australian-rankings/top-medicine/
43. DaRosa DA, Skeff K, Friedland JA, Coburn M, Cox S, Pollart S, et al. Barriers to Effective Teaching. Academic Medicine. 2011 Apr;86(4):453–9.
44. Whittle S, Whelan B, Murdoch-Eaton D. DREEM and beyond; studies of the educational environment as a means for its enhancement. Educ Health [Internet]. 2007 Apr 18 [cited 2023 Feb 20];20(1):7. Available from: https://educationforhealth.net/article.asp?issn=1357-6283;year=2007;volume=20;issue=1;spage=7;epage=7;aulast=Whittle
45. Coentre R, Góis C. Suicidal ideation in medical students: recent insights. Adv Med Educ Pract. 2018 Nov 29;9:873-880. doi: 10.2147/AMEP.S162626. PMID: 30568525; PMCID: PMC6276609.
46. Australian Medical Students' Association. Mental Health and Wellbeing Policy [Internet]. Australian Medical Students' Association:2022 [cited 20 Feb 2023]. Available from: https://www.amsa.org.au/sites/amsa.org.au/files/Mental%20Health%20and%20Wellbeing%20Policy%20%282018%29.pdf
47. Torales J, Castaldelli-Maia JM, Ventriglio A. LGBT + medical students and disclosure of their sexual orientation: more than in and out of the closet. Intl Rev Psych, 34:3-4, 402-406, doi: 10.1080/09540261.2022.2101881
48. Hayward K, Doggett J. Survey reveals 'systemic racism' in medical training [Internet]. Croakley Health Media; 2017 [cited 21 Feb 2023]. Available from: https://www.croakey.org/survey-reveals-systemic-racism-in-medical-training/
49. Timm A. 'It would not be tolerated in any other profession except medicine': survey reporting on undergraduates' exposure to bullying and harassment in their first placement year. BMJ Open. 2014; 4:e005140. doi: 10.1136/bmjopen-2014-005140
50. Hill KA, Samuels EA, Gross CP, Desai MM, Zelin NS, Latimore D, ... & Boatright D. (2020). Assessment of the prevalence of medical student mistreatment by sex, race/ethnicity, and sexual orientation. JAMA Internal Medicine, 180(5), 653-665.
51. Australian Medical Students' Association. Bullying and Harassment in Medicine Policy [Internet]. Australian Medical Students' Association:2019 [cited 20 Feb 2023]. Available from: https://amsa.org.au/common/Uploaded%20files/AMSA/Policy/C/Bullying%20and%20Harassment%20in%20Medicine%20(2019).pdf
52. Australian Medical Students' Association. Sexual Harassment Policy [Internet]. Australian Medical Students' Association:2021 [cited 20 Feb 2023]. Available from: https://amsa.imiscloud.com/common/Uploaded%20files/AMSA/Policy/C/Sexual%20Harassment%20(2021).pdf

53. Southgate C, Band E. The Strange World of Medical School for working-class and indigenous students: Doing extreme social mobility [Internet]. EduResearch Matters. 2017 [cited 21 Feb 2023]. Available from: https://www.aare.edu.au/blog/?p=2430
54. Apply for a blue card or exemption card [Internet]. Queensland Government. The State of Queensland; Queensland; 2023 [cited 2023 Mar 26]. Available from: https://www.qld.gov.au/law/laws-regulated-industries-and-accountability/queensland-laws-and-regulations/regulated-industries-and-licensing/blue-card/applications/apply
55. The State of Queensland; Transport and Main Roads; Evidence of identity [Internet]. Queensland Government. The State of Queensland; Queensland; 2023 [cited 2023 Mar26]. Available from: https://www.qld.gov.au/transport/licensing/driver-licensing/identity
56. Getting a customer reference number - publications.qld.gov.au [Internet]. Getting a Customer Reference Number or updating your photo for your blue card application. Queensland Department of Transport and Main Roads (TMR); [cited 2023 Mar 26]. Available from: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/904d36da-b673-413f-a74d-64d87d45bf65/getting-a-customer-reference-number-03.pdf?ETag=e3bec429b75b628d71e0fd04297ba807
57. Glauser W. How medical schools can better support students who are parents. CMAJ. 2019 Feb 25;191(8):E243-E244. doi: 10.1503/cmaj.109-5707. PMID: 30803959; PMCID: PMC6389454.
58. Australian Medical Students' Association. Medical Students with Dependents Policy [Internet]. Australian Medical Students' Association:2020 [cited 21 Feb 2023]. Available from: https://amsa.imiscloud.com/common/Uploaded%20files/AMSA/Policy/C/Medical%20students%20with%20dependents%20(2020).pdf
59. Williams R. Cultural safety—what does it mean for our work practice?. Australian and New Zealand journal of public health. 1999 Apr;23(2):213-4.
60. Parisa B, Reza N, Afsaneh R, Sarieh P. Cultural safety. Holistic nursing practice. 2016 Jan 1;30(1):W-8.
61. Wepa D, editor. Cultural safety in Aotearoa New Zealand. Cambridge University Press; 2015 May 18.
62. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine SJ, Reid P. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. International journal for equity in health. 2019 Dec;18(1):1-7.
63. Laverty M, McDermott DR, Calma T. Embedding cultural safety in Australia's main health care standards. The Medical Journal of Australia. 2017 Jul 3;207(1):15-6.
64. Phiri J, Dietsch E, Bonner A. Cultural safety and its importance for Australian midwifery practice. Collegian. 2010 Sep 1;17(3):105-11.
65. Wilson AM, Kelly J, Jones M, O'Donnell K, Wilson S, Tonkin E, et al. Working together in Aboriginal health: A framework to guide health professional practice. BMC health services research. 2020;20(1):601–601.
66. Nolan-Isles D, Macniven R, Hunter K, et al. Enablers and Barriers to Accessing Healthcare Services for Aboriginal People in New South Wales, Australia. Int J Environ

Res Public Health. 2021;18(6):3014. Published 2021 Mar 15. doi:10.3390/ijerph18063014

67. Indigenous health and Wellbeing [Internet]. Australian Institute of Health and Welfare. [cited 2023Feb22]. Available from: https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing
68. Australian Medical Students' Association. Aboriginal and Torres Strait Islander Health Policy [Internet]. Australian Medical Students' Association:2019 [cited 22 Feb 2023]. Available from: https://amsa.imiscloud.com/common/Uploaded%20files/AMSA/Policy/F/Aboriginal%20and%20Torres%20Strait%20Islander%20Health%20(2019).pdf
69. Australian Medical Council. Proposed Graduate Outcome Statements: Draft for consultation. [Internet]. Aug 2022. Available from https://www.amc.org.au/wp-content/uploads/2022/09/ATTACHMENT-A-Proposed-Graduate-Outcome-Statements-Draft-for-consultation-August-2022.pdf
70. Transport Accident Commision (TAC) [Internet]. Tired driving. 2022 [cited 17 Feb 2023]. Available from: https://www.tac.vic.gov.au/road-safety/staying-safe/tired-driving#:~:text=Driving
71. King KR, Purcell RA, Quinn SJ, Schoo AM, Walters LK. Supports for medical students during rural clinical placements: factors associated with intention to practise in rural locations. Rural and Remote Health. 2016;16:3791. doi:10.3316/informit.225309907080606
72. Alfred Health [Internet]. Parking at The Alfred. 2023 [cited 18 Feb 2023]. Available from: https://www.alfredhealth.org.au/patients-families-friends/before-you-arrive/parking-at-the-alfred
73. St Vincent's Hospital Sydney [Internet]. Parking at the Alfred. 2023 [cited 18 Feb 2023]. Available from: https://www.svhs.org.au/patients-visitors/coming-to-st-vincents/parking
74. Roe I. NSW student doctors to get paid jobs in hospitals in bid to ease staff shortages. ABC News. 2022; https://www.abc.net.au/news/2022-11-27/nsw-student-doctors-get-paid-positions-to-ease-shortages/101703440:
75. NSW Health. Assistant in Medicine Evaluation Report [Internet]. Sydney: NSW Health. 2021 May [cited 2023 Mar 24]. 40 p. Available from: https://www.health.nsw.gov.au/workforce/medical/Publications/aim-evaluation-report.pdf
76. Queensland Health. Health Employment Directive [Internet]. Brisbane: Queensland Health. 2022 Nov 01 [cited 2023 Mar 24]. 4 p. Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0036/1184868/HED-05.22-Employment-framework-Students-in-Medicine.pdf
77. Monrouxe LV, Hockey P, Khanna P, et al. Senior medical students as assistants in medicine in COVID-19 crisis: a realist evaluation protocol. BMJ open. 2021;11(9):e045822-. doi:10.1136/bmjopen-2020-045822
78. Davis DJ, Moon M, Kennedy S, DelBasso S, Forman HP, Bokhari SA. Introducing medical students to radiology as paid emergency department triage assistants. J Am Coll Radiol. 2011;8(10):710-715. doi:10.1016/j.jacr.2011.06.002

79. Stevenson E, Smith-Han K, Nicholson H. Medical students' experience of studying while working part-time and the effects of COVID-19. N Z Med J. 2022;135(1557):38-48. Published 2022 Jul 1.
80. Monjur R. COVID-19: medical students in the Assistant in Medicine [Internet]. NSW: MJA; [2020 Jul 13; cited 2023 Mar 25]. Available from: https://insightplus.mja.com.au/2020/27/covid-19-medical-students-in-the-assistant-in-medicine-program/

Policy Details:

Name: Clinical Placements and Remunerated Medical Student Positions (2023)

Category: B – Medical Education

History: **Reviewed Council 1, 2023**

Meredyth Lee, Patrick Rosengren, Alexandra Wilson, Olusina Omifolaji, Jayatee Banerjee, Isabelle Townend, Kermina Kiriacos; with Ebony Layton (National Policy Mentor) and Connor Ryan (National Policy Officer – Executive).

Reviewed Council 3, 2019 as merger of 'Quality Clinical Placements' and 'Shared Clinical Placements'.

Adopted Council 2, 2016 (Quality Clinical Placements).

Reviewed Council 3, 2015 (Shared Clinical Placements).

Adopted Council 1, 2008 (Shared Clinical Placements).