Policy Document

Medical School Learning Conditions

Position Statement

The Australian Medical Students' Association (AMSA) believes that:

1. Medical students have the right to a safe, fair, and protected study and placement environment;
2. Flexibility in teaching, learning, and assessment is conducive to student wellbeing and performance;
3. Medical schools and health services have a responsibility to support and facilitate student welfare;
4. Some policies and practices of medical schools and hospitals have contributed to poor student wellbeing, burnout, and mental ill health, and thus;
5. All stakeholders have a responsibility to work collaboratively to improve and maintain good conditions for medical students in preclinical and clinical environments.

Policy

AMSA calls upon:

1. The Australian Medical Council (AMC) to:
    a. Expand existing and impose additional accreditation standards upon primary medical programs which address:
        i. Safe and supported learning environments,
        ii. Adequate communication and consultation with students on issues that affect them,
        iii. Burnout prevention strategies, and,
        iv. Monitoring of student health and wellbeing.
    b. Provide representative student societies the opportunity for non-structured discussion of their medical program in addition to regular progress reports;
    c. Extensively consult with student groups, including AMSA, Medical Student Councils, and Medical Societies, when reviewing accreditation standards and procedures
2. Medical Deans Australia and New Zealand (MDANZ) to:
    a. Revise *Inherent Requirements for Medical School in Australia and New Zealand* to acknowledge the role of medical schools and organisations in supporting student mental health and wellbeing;
3. Australian medical schools and faculties to:
    a. Implement flexible content delivery, including but not limited to:
        i. Part time study,
        ii. Evening classes,
        iii. Mixed-method course delivery,
        iv. Intensive or block study course delivery;
    b. Remove 100% mandatory attendance requirements in preclinical and clinical settings;
    c. Ensure that there is sufficient advance notice for the scheduling and alteration of student timetables;

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d. Ensure that students are granted sufficient leave for personal reasons without significant barriers including but not limited to:
    i. Medical leave,
    ii. Carers leave,
    iii. Bereavement leave,
    iv. Parental leave,
    v. Leave pertaining to cultural obligations;
e. Ensure methods used to determine and record attendance respect students' privacy;
f. Reserve remediation of missed contact hours only for instances that may result in an inability to attain required competencies for academic progression;
g. Refrain from implementing punitive policies regarding absenteeism, particularly policies that view it as unprofessional behaviour;
h. Implement policies and provide resources to support students with poor attendance to return to study;
i. Actively advertise and clearly communicate available accommodations for learning, such as special consideration, academic mentorship, reasonable adjustments, mental health and independent advocate services;
j. Ensure that all students have access to a safe environment to practise clinical skills, such as a simulation laboratory;
k. Ensure that all students have access to safe, effective, and anonymous reporting procedures for students experiencing workplace bullying, harassment, racism and discrimination that prioritise the safety and wellbeing of the student;
l. Ensure that students have structured, protected formal teaching while on clinical placements within regular business hours;
m. Ensure that students have sufficient, protected rest breaks between shifts while on clinical placements;
n. Provide education and training on managing workplace violence and aggression prior to commencement of clinical placement;
o. Provide placement shifts outside of standard business hours through an opt-in or opt-out process only;
p. Ensure that student teaching and participation in practice is concordance with students' stage of training, competence, and confidence;

4. Health services to:
    a. Provide adequate facilities and services to support students on placement, including but not limited to:
        i. Secure, accessible common spaces;
        ii. Free or affordable parking; and
        iii. Security escorts if desired to appropriate transport.
5. The Australian Medical Students' Association (AMSA) Executive to:
    a. Continue to develop new and strengthen existing policies addressing medical student wellbeing and safety;
    b. Investigate the clinical placement conditions of Australian medical students in hospitals.

Background

The Australian Medical Students' Association (AMSA) is the peak representative body of Australia's 17,000 medical students. Accordingly, AMSA has a long history for advocating for policy changes that improve the welfare of medical students. Ensuring safe learning environments that promote good health is therefore key to AMSA's work.

Rostering and timetabling

Flexible rostering and timetabling in medical school is associated with greater academic productivity, interest in research, and mental health [1]. Increased flexibility in timetabling of lectures and rostering of clinical shifts is associated with an enhanced ability to cope with stress factors [2].

Students surveyed in a 2019 qualitative study identified confusing attendance policies, poor timetabling, and late addition or cancellation of teaching content to timetables as major stressors [2]. Students with external carer, work, or extracurricular commitments were disproportionately affected by poor timetabling, as were students commuting longer distances to universities or clinical sites.

Medical students identified earlier class and examination date announcements, increased flexibility, and fewer mandatory sessions as beneficial to wellbeing and burnout prevention [3].

Shifts and protected time

Students are expected to assimilate into the hours kept by staff on clinical placement. These placements principally occur over morning and afternoon shifts, but students are occasionally called to undertake night or weekend shifts. During these placements, students are expected to prioritise placement over non-clinical commitments, such as work or personal demands. Surveys of doctors and medical students show that long working hours combined with competing work and personal demands contribute to significant levels of burnout and poor mental health [4].

The Australian Medical Association (AMA)'s *National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors* lays out a set of scheduling design principles which aim to eliminate fatigue-related health risk to workers and students [5]. These principles include minimising the number of shifts exceeding 10 hours, ensuring breaks between shifts enable at least 8 hours of continuous sleep, and offering covering contingencies in the event of sickness or other extenuating circumstances. The scheduling design principles recognise that fatigue, sleep deprivation, and circadian rhythm disruption are associated with human error and may pose a risk of harm to both student and patient [6].

Inadequate scheduling of structured teaching time for medical students on placement has been cited as a significant barrier to effective medical education [7]. This is largely due to the implementation of ineffective teaching methods and lack of time [8, 9]. Medical students would prefer a curriculum structure that includes both bedside teaching and formal teaching sessions [2, 10]. The hours of clinical placement students are required to undertake often varies by hospital, specialty and team, creating a significant barrier to structured teaching.

Medical students have reported a significant increase in stress and burnout when teaching sessions occurred outside of regular teaching hours [2]. While the definition of regular teaching hours varies between universities, they typically fall between 8am-6pm Monday to Friday [11]. Thus, formal teaching sessions should be incorporated as an important part of clinical placement but only within reasonable hours to protect mental health and prevent burnout.

Attendance requirements and leave

There is no national standard across Australian medical schools dictating attendance requirements. Attendance is often construed as a marker of professionalism [12]; thus many medical programs require 100% attendance for clinical activities, but there remains significant variability across schools [11, 13, 14]. Whilst accumulating placement hours is of paramount importance in acquiring adequate clinical knowledge and accreditation, attendance in class is not an appropriate surrogate measure of performance [15, 16]. Some medical schools monitor attendance through GPS tracking technologies such as OSLER [13]. These methods threaten students' privacy and autonomy and perpetuate a culture of presenteeism. Mandatory attendance and strict regulation of absenteeism is a contributor to poor mental health and burnout amongst medical students [2, 17].

Where students are unable to attend placement, due to illness, bereavement or other extenuating circumstances, they are often required to provide supporting documentation for their absence, such as a medical certificate as proof of illness [13]. Such practices can deter students from taking short-term leave - for example, to recover from mild illnesses - as the process of getting medical documentation poses an undue burden. These leave of absence policies contribute to a broader culture that encourages presenteeism, a prevalent phenomenon amongst both students and junior medical staff, used to avoid the negative repercussions of non-attendance [18]. These behaviours have negative health consequences for students, patients and other staff, and reduce productivity [19]. In cases where absenteeism is symptomatic of an underlying issue, such as psychological distress, mandatory attendance requirements and punitive blanket policies may exacerbate underlying issues rather than supporting students [12, 16].

In addition to documented proof, it is common practice for medical schools to request that students prepare a learning plan to remediate hours “lost” to non-attendance, even where absence is approved. Remediation, in the form of additional contact hours or assignments, increases the already substantial workload of medical school, and contributes to burnout [14].

By comparison, enterprise agreements for medical officers across Australia acknowledge that medicine is not the only demand on an individual’s time, and that extenuating circumstances can be unpredictable. Hospitals recognise that working through sickness, bereavement or other extenuating circumstances is not conducive to wellbeing or workplace productivity, and medical officers across Australia are entitled to short-term personal/carer’s leave [20]. For example, interns in Victoria wanting to invoke personal/carer’s leave are required to notify their health service two hours prior to their shift with no substantiating evidence required [21]. Only after three single day absences is a medical certificate or relevant documentation is required [21]. Professional behaviour standards such as attendance are often touted as a method of preparation for the workplace; however, in the case of attendance, these standards are not a realistic reflection of working conditions for medical officers.

Reasonable adjustments for learning

The provision of reasonable adjustments for Australian medical students is, at present, provided on an adhoc basis [22-25]. University accessibility, disability and inclusion services are delivered by universities centrally, with students requesting support that is tailored to their individual circumstances [26]. As expected, this assistance is provided on a case-by-case basis [27].

It is a misconception that incorporating accommodations into an academic environment weakens the ability for performance standards to be met [28]. Providing students with learning accommodations is desirable from both a practical and ethical perspective [28].

Medical schools have a responsibility to create an environment which is inclusive and supportive of a diverse student body. This necessitates a cooperative and collaborative case management approach to dealing with individual students [29].

Whilst certain medical schools explicitly state that there is room for reasonable adjustments to manage additional circumstances, there is limited publicly accessible evidence regarding pre-determined protocols for accommodating students [30]. It is therefore likely that this opacity is also seen in how accommodations are made for students in the clinical environment.

Facilities and infrastructure

Access to appropriate facilities and infrastructure is an essential component of a comprehensive medical education. MDANZ defines the infrastructure requirements for quality clinical placement as access to consultation rooms, clinical skills laboratories, teaching spaces, IT infrastructure and access to suitable accommodation for students located in rural and remote areas [7]. This is supported by multiple studies which cite inappropriate physical facilities and insufficient IT resources as significant barriers to effective medical education [9, 31].

The *AMA National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors* provides a series of recommendations for facilities that doctors and students should have access to while in the hospital [5]. This includes rest areas to take short breaks, lockers or other areas to store belongings, showers and suitable facilities to sleep if required on an overnight or late shift. However, student access to these facilities is often limited and left to the discretion of the hospital. Medical student lack of experience, when combined with fatigue, results in significant risks to safety and thus, student access is absolutely necessary. Importantly, students have reported that teaching spaces in close proximity to the hospital are beneficial, reducing time commuting between locations [32].

Access to simulation and clinical skills laboratories provide students with the opportunity to practice their skills and make mistakes in a controlled and safe environment [7]. Access to these facilities are especially important in the private sector, where exposure and opportunity to practice skills can be limited. Thus where students are unable to practice these skills they must be provided with clinical skills laboratories or simulations.

Student safety

Violence against healthcare workers is a serious issue and is increasing [35, 36]. In Australia 70.6% of doctors reported experiencing written or verbal aggression, and 32.3% experienced physical aggression in a 12 month period [37]. Violence can cause short and long term consequences, both psychologically and physically, and can contribute to burnout [38]. Medical students on clinical placement are exposed to these same environments in which they may be victim to patient aggression or abuse. The AMA has developed a *Safe Work Environments Position Statement* directed at ensuring the wellbeing and safety of doctors whilst at work, and which may be used as a guide to direct and inform safe working conditions for medical students [39].

In addition to workplace design, adequate training to improve communication skills, including de-escalation techniques, and identify situations which may escalate and thus may require additional help promptly, have been suggested as being key to preventing workplace aggression [36, 40, 41]. Safety is not only an issue inside the hospital but also upon leaving the hospital, particularly after hours. Hospitals are encouraged to provide staff with access to discounted parking and the availability of security escort to their cars after hours [47]. Medical students are often required to come to hospital after hours for clinical placement but do not implicitly have access to these measures. Furthermore, many medical students as full time students may lack

the financial means to afford parking fees even at discounted staff parking rates.

In addition to protection against violence in the workplace, there are many other factors that contribute to student safety, including adequate access to PPE and protection from infectious diseases, which are discussed in detail in AMSA's *Pandemics* (2020) and *Clinical Placement Compliance* (2020) policies.

Scope of practice

The onus falls on the teaching or healthcare organisation to ascertain and delineate the clinical scope of practice for medical students [33]. RACGP guidelines for supervising general practitioners suggest that experiences afforded to medical students should be in concordance with the student's stage of training, competence, and confidence [34].

Sexual harassment and bullying

The medical workplace is subject to elevated levels of sexual harassment and bullying and medical students are particularly vulnerable in this regard. While some policies and reporting mechanisms exist, medical students continue to report disproportionate levels of harassment. The effects of bullying and harassment can have acute and long term consequences, and are covered in depth in AMSA's *Bullying and Harassment in Medicine* (2019) and *Sexual Harassment Policy* (2019).

The current culture in the medical workplace restricts reporting of inappropriate behaviour and risks the continuation of the cycle of normalisation [42]. The prevention of such a continuation must come from within and necessitates the removal of certain barriers to allow for adequate reporting of inappropriate behaviour.

A questionnaire assessing the prevalence and nature of workplace sexual harassment of medical students revealed that in addition to enduring bullying and sexual harassment from medical stuff, up to 71% of medical students experience patient-initiated sexual behaviour [43]. The occurrence of such interactions undermines the relationship with the patient and causes undue distress for the medical student. The study allowed for students to provide comments, where a clear loss of confidence and lack of clarity in escalation pathways was present: "...Didn't know what sort of 'management' notification or action should be taken… Lost confidence seeing patients alone for about six weeks." Importantly, the major category of harasser in this study was found to be fellow students, particularly in pre-clinical years [43]. This highlights the importance of early intervention of workplace culture practices so as to halt the propagation of the current cycle.

Medical students have reported uncertainty of how to raise concerns, fear of repercussion and uncertainty of validity of concerns as major barriers to combatting sexual harassment and bullying in the workplace [40]. In the absence of clear escalation pathways that are confidently anonymous, medical students are rendered disempowered and in many cases traumatised. This is supported in a study assessing medical student perspectives, with greater response rates when only information regarding gender and year of training were collected [43].

Practices of teaching by humiliation, also known as academic intimidation, is prevalent in standard medical teaching and has detrimental effects on medical student wellbeing and career satisfaction [44]. This practice has persisted as a 'transgenerational legacy,' with each generation of medical practitioners becoming indoctrinated in a curriculum of abuse [45]. Ongoing efforts targeted at addressing bullying at the law, policy, and programmatic levels

In addition to unclear escalation and reporting pathways, medical students identified normalisation of inappropriate behaviour a significant barrier in taking action [46]. Workshops directed toward both teachers and students involving re-enactment and

discussion of reported harassment has been seen to raise sensitivity and awareness of sexual harassment and bullying as well as encouraging reflexivity in daily routines [47].

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Policy Details

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