Policy Document

Rural Clinical Schools (2021)

Position Statement

The Australian Medical Students Association (AMSA) believes that:

1. Rural Clinical Schools play a dynamic role in the clinical education of medical students and provide a pathway to future rural workforce retention.
2. Rural Clinical Schools must receive sufficient financial and academic support to incentivise, encourage and mitigate barriers to accessing Rural Clinical Schools.
3. Attracting medical students towards Rural Clinical Schools is dependent on lifestyle factors including liveability of communities, economic considerations, and social opportunities provided by the Rural Clinical School environment.
4. All students, regardless of status of their enrolment, should be provided the opportunity to attend Rural Clinical Schools and expressions of future rural intent should be considered when selecting students to attend Rural Clinical Schools.
5. Rural Clinical Schools should not be used as a substitute in the Commonwealth government's funding towards other rural medical initiatives for medical students.
6. Thorough and regular evaluation of Rural Clinical Schools through a standardised survey framework should be implemented to ensure consistency and cohesive clinical experiences between all Rural Clinical Schools.
7. Rural Clinical Schools provide a robust experience in expanding Indigenous Health in medical schools, but placements and contact must be culturally safe and done so in consultation with local Aboriginal and Torres Strait Islander communities and health services so as to not impede on Indigenous people.

Policy

AMSA calls upon:

1. The Commonwealth Government to:
    a. Ensure that Rural Clinical Schools are adequately funded to deliver high quality medical education, including:
        i. Being separate from rural end-to-end preclinical medical school education resources;
        ii. Providing a high standard of financial subsidies for students including:
            1. relocation costs;
            2. accommodation; and
            3. transport for the duration of their placement;
    b. Support more extended rural placements at Rural Clinical Schools;
    c. Support doctors involved in rural clinical school teaching in the form of continuing medical education, professional development points and practice incentive payments;
    d. Implement the recommendations of the Rural Health Multidisciplinary Training Program Evaluation (2020);

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e. Employ accountability frameworks and monitoring of each Rural Clinical School's expenditure and placement quota targets and quality;
f. Collect longitudinal data regarding the career outcomes of students who attend Rural Clinical Schools;

2. The Australian Medical Council to:
    a. Ensure Universities are assessed on their success of promoting and encouraging graduates to pursue a rural health career;
    b. Develop additional standards to assess the quality of university Rural Clinical Schools as part of the medical school accreditation process
    c. Establish standardised monitoring and evaluation procedures for Rural Clinical Schools for students to provide feedback;
3. Australian Medical Schools to:
    a. Employ strategies and provide incentives to attract medical students to undertake clinical placements at rural clinical schools including but not limited to:
        i. Providing a high standard of financial subsidies for students including:
            1. relocation costs;
            2. accommodation; and
            3. transport for the duration of their placement;
    b. Allow all students to preference Rural Clinical School places using an opt-in system and;
        i. Consider other measures, such as rural student status, as a last resort
        ii. implement measures that allow students to show their intention to work rurally;
    c. Provide subsidised accommodation to students undertaking rural placements irrespective of the duration;
    d. Ensure students undertake their university examinations at their Rural Clinical Schools and when unable to; allocate transport allowances and accommodation at the examination location;
    e. Provide rural placement opportunities to international students by redirecting international student fees towards Rural Clinical School attendance;
    f. Support the allocation of international students to Rural Clinical Schools by:
        i. ensuring opportunities for rural placement are equal for domestic and international students;
        ii. Redirecting international student fees to achieve international student rural placement;
    g. Ensure staff responsible for the governance and implementation of Rural Clinical Schools programs are based at the Rural Clinical School;
    h. Provide research funding and opportunities to staff and students at Rural Clinical Schools;
    i. Support the exit and intermission of students from participation in Rural Clinical Schools through special consideration of factors including;
        i. physical and mental health illnesses;
        ii. caring responsibilities;
        iii. financial difficulty;

4. Rural Clinical Schools to:
    a. Assist students in various needs that arise from relocating to a new community and environment including, but not limited to:
        i. Assisting students to access bulk billed health services, including medical and counselling services;
        ii. Allowing time for students to acclimatise to their Rural Clinical School community prior to formal education starting;
        iii. Supporting students to integrate into the community through facilitating participation in local community activities;
        iv. Providing appropriate resourcing and escalation pathways to address the challenges faced by international students and culturally and linguistically diverse students placed rurally inline with the Racism and Cultural Diversity and Bullying and Harassment policies;
    b. Provide students with opportunities to participate in both clinical and laboratory based medical research;
    c. Provide access to infrastructure including study spaces, student common areas, internet and library facilities;
    d. Offer wellbeing and personal development days;
    e. Ensure rural placements are conducted in a culturally safe way that minimises any potential harm to Aboriginal and Torres Strait Islander communities by:
        i. Providing culturally sensitive training specific to the history, environment, culture of the Aboriginal and Torres Strait Islander community at the clinical school location;
        ii. Ensuring adequate consultation with Aboriginal and Torres Strait Islander communities and Aboriginal Community-Controlled Health Organisations (ACCHOs) about the placement of medical students in their communities to ensure they are able to facilitate students and that these placements are sustainable; and
        iii. Being flexible in their clinical school options for Aboriginal and Torres Strait Islander Students who may want to gain experience in specific rural communities with which they may have a connection;
        iv. Having the acceptance of the Indigenous community and respect their culture and boundaries.
5. The Australian Medical Students' Association to:
    a. Consider Rural Clinical School students when delivering opportunities and events with reducing barriers to access including;
        i. the provision of hybrid online/in-person events;
        ii. financial support to attend in-person only events.
6. Medical Student Societies to:
    a. Seek comment from students studying at Rural Clinical Schools for specific inclusion in AMC review reports

Background

The Australian Medical Students' Association (AMSA) is the peak representative body for medical students in Australia. It is imperative that all students have the opportunity to experience clinical medicine in a regional or rural setting for both a well-rounded medical education and to encourage future workforce retention. AMSA advocates for evidence-based funding towards Rural Clinical Schools (RCS), a consistent RCS experience across all rural sites, equivalent learning opportunities of RCS despite differing institutions, and for lifestyle allowances to be considered to encourage students to partake in RCS.

Rural Clinical Schools

RCS are funded through the Department of Health, and are a substantial investment [1) in the effort to rectify the shortage of medical doctors in rural areas [2]. RCS are expected to deliver substantial components of medical education within the scope of a rural environment consistent with the Australian Medical Council's curriculum requirements, regardless of location[3]. Studies show that the RCS program for clinical students has a positive future effect on the regional medical workforce [4]. However, individuals' future considerations, including training, significantly influences time spent as junior doctors in regional and rural areas [2].

At least 25% of Commonwealth Supported Place(CSP)-funded medical students must undertake a placement of a minimum of one year at a clinical site in an area dictated by its RA status of 2-5 [3]. 50% of CSP-funded medical students must also undertake a rural training experience of at least four weeks throughout the duration of their medical degree [5]. There are two predominant clinical placements facilitated by RCS: within regional hospitals and within general practice in smaller communities[5]. There is currently no requirement for international students to have exposure to RCS, nor does the funding from the Australian government take international students into consideration.

<u>Rural Health Multidisciplinary Program</u>

In 2016 the Australian Government Department of Health consolidated several key education and training programs for students of medicine, dentistry, allied health and nursing, and created the Rural Health Multidisciplinary Training Program (RHMT)[6]. The RHMT program involves 21 different university institutions, and funds 19 RCS and 16 Departments of Rural Health to support the training of health students to continue their careers in regional and rural Australia [5]. The RHMT has facilitated an increase of the tertiary education presence in rural Australia, created local academic networks and built new infrastructure [5]. Away from the educational purposes of the RHMT program, it has allowed critical enhancements of regional hospitals, and strengthened clinical service delivery across Australia [5]. The RHMT program is the major facilitator of RCS through the government's funding of it, and is an important consideration in the longevity of RCS.

An independent evaluation of the RHMT program by KBC Australia, a consulting firm, [5] has shown the program itself, and thus RCS, have developed health teaching innovation in rural, remote and regional settings[5]. RCS through RHMT funding has created a strong positive impact of longer term rural medical placements that influence future rural workforce outcomes[5], with the exposure encouraging more to go rural as doctors. The RHMT program has facilitated community benefits of RCS, with direct economic stimulus into communities and regions universities have invested in[5]. However, there were significant areas for improvement across the domains of placement quality, ongoing evaluation, supervision, research and student

support [5]. An important factor to consider with RCS funding and educational machinations is that each RCS is connected to the RHMT program, but not necessarily through a Regional Training Hub [7], another government health funding initiative in regional and rural Australia

Student Selection

Each university utilises differing criteria and mechanisms to select students to attend RCS [5]. Factors that are often considered are the rural background-status of medical students, if they are a participant in the bonded medical program (BMP)[1], and participation in rural activities prior to RCS academic years. However, the concept of medical students' 'self-efficacy' has been shown to be a strong factor in one's decision to practise rurally as medical doctors [8]. This self-efficacy is described as the self-belief in one's own competence, with more independent minded students exhibiting this self-efficacy, thus desire to attend a RCS and be an eventual rural workforce participant [9]. Another factor which increases the likelihood of becoming a rural workforce participant is the intention to work as a generalist [10].

Thus, the impetus of each individual student should be the driving factor in RCS student selection, over rural background and BMP participation in isolation. As it stands, students trained only in a metropolitan capacity contribute equally to the rural workforce capacity, showing that there is scope for student selection to be widened by institutions by considering future intention over current student status[11]. To further this issue, the rate of completing the return of service for BMP students indicates that other challenges prevent them working rurally[12]. Thus, participation in RCS should be based on students exhibiting interest, and future desire to contribute to a rural workforce, over parameters assigned to them at the start of medical school.

Regional and rural 'end-to-end' medical schools

End-to-end medical school programs are a medical education initiative that have medical students staying in regional and rural areas defined by their Modified Monash Model of greater than or equal to 3 for the entirety of their degrees [13]. End-to-end medical students begin with preclinical education and stay in these locations up until their graduation [14]. The model of regional and rural 'end-to-end'[15] medical schools has evolved from the philosophy that there is a positive correlation between having an immersion in regional and rural areas as a medical student and electing to become a rural intern [16]. It is believed by the Australian government that RCS have not gone far enough in addressing the maldistribution of domestic graduates and the rural workforce [17], thus medical schools are now establishing campuses that facilitate rural exposure not just in the clinical years through RCS, but in preclinical years as well [15]. The delivery of these 'end-to-end' medical schools through models such as the Murray Darling Medical School Network [15] and Regional Medical Pathway [18] are reliant on studies based on RCS experience and exposure. Many of the new medical school end-to-end programs are also being delivered from locations that already have RCS [19]. The imposition of end to end medical places on the access of metropolitan based preclinical medical students to rural placements has not been fully evaluated or studied [20], with a potential deficit of clinical exposures and experiences in RCS due to an increase in student numbers at rural sites being posited.

The aims of Rural Clinical Schools

Rationale behind RCS

Since their implementation, RCS have significantly contributed to their respective communities and have afforded opportunities for students to engage more meaningfully with their rural placements[1, 21]. Regardless of a student's background, undertaking a rural placement in medical school is associated with an increase in willingness to work rurally after graduation, particularly as an intern and early career

medical officer[22-24]. This interest is proportional to the number of years spent rurally[9, 11]. Participating in a year-long placement in a RCS is associated with an 83% increase in interest to practise rural medicine[25]. There is currently a disparity in the distribution of RCS locations, with many being found in inner regional centres [Modified Monash Model Remoteness Area (MMM-RA)] and comparatively few in smaller communities. As rurality of clinical schools and placement settings are strong predictors for rural practise in the future, an increased effort may be needed to prioritise student rotations through clinics in these smaller communities and towns of RA 3-7 to reflect the workforce demand[26]. It is important to consider these placements in other, more rural, environments still meet the student support at home RCS to prevent bad outcomes in increasingly rural locales.

Future workplace implications of RCS

According to the AMSA Rural Student Support Report Card, 45.2% of respondents reported an intention to practice rurally in the future by choice[27]. However, despite positive RCS experience, the lack of continuity of rural medical training is a significant challenge to rural career outcomes. RCS are well positioned to integrate into larger rural training pathways, with students streamlined from their RCS into regional internship positions[1]. A recent Victorian study reported that uptake of rural internship positions by domestic graduates is sub-optimal, not reaching targets for growing a rural workforce from local graduates [28]. This is most likely due to a number of barriers to participating in a rural internship and its perceived impacts on career progression [29]. Therefore, strategies are urgently needed to increase the attractiveness and/ or combat those barriers and perceptions of rural internships for domestic students, otherwise the vicious cycle of reliance on international graduates to maintain the already fragile workforce will continue to transpire.

The availability of rural-based training programs and vocational training posts are important factors in facilitating rural retention[1, 2, 21]. Several government initiatives exist to elicit positive workforce distribution. The Specialist Training Program (STP) offers vocational training opportunities in settings outside of metropolitan areas. Under the STP, the Integrated Rural Training Pipeline (IRTP) complements the role of RCS by seeking to help stream students through the medical training pipeline by establishing twenty-six regional training hubs through the funding of the RHMT Program, and then guiding students and trainees through these hubs[5]. There is a significant association between rural training pathways and subsequent rural practice[2].

The introduction of the IRTP initiative in 2016 was created to overcome this challenge by establishing regional training hubs where specialist trainees have the opportunity to complete two thirds of their training within a rural region[30]. From 2021-2022, the Australian Government will be investing in a new innovative funding pool for non-GP medical specialist training which aims to provide flexibility to support and promote growth in specialist medical training and deliver better distribution and supply of specialists matched to community health needs, especially in rural and remote Australia. Although progressing in the right direction, the current funding models support only 100 speciality training program positions [31]. Thus, this leaves RCS to bear the burden of this longitudinal issue.

Positive Rural Clinical School Factors

It has been identified that elements of a high quality placement include a variety of factors not limited to: having access to free or highly subsidised accommodation, the quality of supervision, clear learning outcomes of the clinical placement, opportunities for community engagement and opportunity to provide feedback and evaluation for improvement[32].

Community Connections in Rural Clinical Schools

The provision of quality placements in RCS and their reputation in providing unique opportunities, away from a metropolitan setting, for students is imperative for the long-term continuation of RCS. RCS have the advantage over metropolitan based placements in that they are able to provide more small group learning, and increased patient interactions, with a focus on continuity of care [33, 34]. Outside of the day-to-day medical education, students perceive that living and engaging in these rural communities has a positive influence on their experience as a whole, something that metropolitan placements are unable to provide in the same manner[35]. This community engagement often plays a large role in a student's perception of what their career may look like in the future, with many citing it as a contributing factor when their intent on location of practise changes after their year at a RCS[23].

The interprofessional collaboration and multidisciplinary exposure is also more profound at RCS hospitals and medical practices[35-37]. Placement at a RCS during clinical years provides students with a 'hands-on' approach and diversity of the clinical environment compared to their metropolitan equivalents[36]. The positives of RCS experiences on metropolitan-based medical students in particular has even been described to 'erode intrinsic interest'[38] in future metropolitan careers.

Issues of Rural Clinical Schools

The quality and experiences of the placements delivered by RCS are not universal between institutions, and vary between medical schools, locations, and medical services allocated to each RCS [27]. The Australian Medical Council does not currently assess RCS in isolation away from their hosting institutions unless the programs result in distinct qualifications[39]. With the varying qualities and experiences between RCS, the utilisation of a standardised report card system could mitigate some of the variances between institutions and RCS. One example of differing experiences of RCS despite the same hospital facility being used is the accessibility of obstetrics placements for The University of Sydney RCS students at Lismore Base Hospital[40], that is not offered for Western Sydney University RCS students[41].

Financial Implications

RCS programs are funded under the RHMT Program[5]. The discretion of how these funds are utilised is given to the RCS, whether that be subsidised student accommodation, infrastructure, or employment of local staff[5]. Referred to as the 'hidden curriculum', many students perceive that the quality of their rural placement is inextricably linked to the financial support they receive[34].

Across universities there is a significant variation in reported financial support offered to students. This may be in the form of travel reimbursements, accommodation subsidies and general university funded rural bursaries. Concerningly, 48% of students report experiencing financial stress during their rural placement, most often due to the limited availability of employment options, insufficient assistance to cover the cost of living and cost of travel between placement sites[27]

Relocation allowances, travel concessions, and subsidised accommodation should therefore be the major financial compensatory measures for students attending RCS[32]. In addition, students should be allowed to undertake their exams at their respective RCS, or where this is not possible, the provision of accommodation subsidies should be provided. Without the burden of these financial stressors, students will have a greater ability to focus on learning, participating in the

communities they are living and therefore get the most out of their rural placements[42].

Personal Barriers to Participation in RCS

Many negative connotations towards RCS do not come from the education quality or opportunities afforded to students on rural placement, rather from the personal circumstances that are impacted whilst attending RCS. Family commitments and other personal relationships are highlighted as major factors in people not willing to commit to RCS[38]. Housing and employment responsibilities are also factors highlighted as barriers towards attending RCS[38]. As the concept of medical student diversity grows within selection processes[43], these personal factors prohibiting students from attending RCS could become more acute with more mature aged students, parents, and second-career medical students becoming more prevalent in medical student cohorts.

The potential feelings of alienation for culturally and linguistically diverse (CALD) students in more homogenous rural locations over metropolitan based medical settings is another potential deterrent that leads to a barrier in attending a RCS. There is a dearth of literature on CALD medical students' experience of discrimination in rural areas, however evidence from qualified nurses of CALD backgrounds describes experiences of discrimination from staff, discomfort from patients, and lack of trust from both these parties[44]. This study reflects anecdotal experiences of medical students within Australia. It is therefore important for RCS to provide strong support structures and escalation pathways for students on placement.

Academic and Research Opportunities

Although promising rich hands-on learning experiences, 57.8% of students reported feeling academically isolated during their time at a RCS [45, 46]. It is hypothesised to be due to a perception of academic disadvantage and lack of academic support amongst RCS students which results in higher levels of stress, burnout and poor student wellbeing [46, 47]. The literature has identified a correlation between higher levels of stress and subsequent willingness for rural work in the future[47].Thus, providing sufficient academic support assists in maintaining student wellbeing, which is essential for the long term success of RCS programs[48].

69% of students have an interest in conducting research as part of their future medical careers [46]. Beginning research in medical school is the traditional pathway into research and aids in networking. However, completing placement at a RCS, then partaking in Rural Internship and Rural Generalist training outside metropolitan hospitals is perceived as a barrier to research due to lack of access. The lack of clinical trials, access to laboratories, and bias towards public health research in regional and rural areas can negatively impact future speciality training applications which require first author publications as part of their curriculum vitae ranking system [29, 48]. These barriers create challenges for rural-educated medical students that their metropolitan counterparts do not face.

Wellbeing at RCS

According to the most recent AMSA Rural Student Support Report Card, only 27.1% of respondents felt that their health and wellbeing were positively impacted by their time in RCS [27]. Factors contributing to negative student wellbeing at RCS include being a mature-aged student, social isolation and poor access to mental health, academic and financial support[46].

With regards to graduate entry students over 30, many felt that their wellbeing and academic performance was negatively impacted by the increased anxiety and stress associated with balancing medicine with family, as well as financial and partner

obligations being so far away from home [49]. Similarly, 31.6% [46] of students at RCS felt socially isolated due to lack of social support structures and recreational activities to unwind and enjoy one's time rurally[50]. This stress and isolation is compounded by barriers to mental health support that are still experienced by nearly 40.8% of RCS students[45]. In the AMSA Rural Health study [27], 35.0% of respondents felt that mental health services were not readily accessible at RCS, with over 28.2% of students unsure if they even had access to mental health services, and only 63.8% reporting having access to a GP clinic for mental health support.

Barriers to mental health identified in the AMSA Rural Health study include the out-of-pocket costs encountered by over 41.4% of students which deterred over 21.5% of respondents from seeking care, as well as the long waiting times that impaired access to care reported by over 26.6% of participants [27]. The AMSA Rural Health study also found that 26.6% of participants reported feeling uncomfortable accessing mental health services for a variety of reasons including the close association of mental health services with teaching sites [13.0%], as well as the tight-knit nature of small rural communities [22.6%][27]. Studies strongly show that this lack of support decreases mental wellbeing and the feeling of academic support in RCS[51]. Moreover, 14.7% of students in the AMSA Rural Health study reported that they did not feel supported by their university, with a further 22.0% of respondents owing this to a lack of structured academic teaching[27].32.2% of respondents considering the teaching to only be of "average" standard[27]. In these cases, students felt that having an unapproachable and unsupportive supervisor contributed to a negative work environment and negatively impacted one's wellbeing and academic performance in RCS [52].

Desire to undertake a rural placement also impacted student wellbeing at RCS as the 32.1% [27] of respondents who were unwillingly allocated into RCS fostered negative attitudes towards their placement. Studies found that these attitudes created a confirmation bias against going rural, clouding their perception of the RCS experience moving forward, through increased anxiety, disengagement, and social isolation, and lead to decreased wellbeing and poorer academic performance[45].

International Students and RCS

Although 90% of international students were willing to work rurally in a recent survey conducted between AMSA Rural Health and the ISN [n=280][53], significant barriers exist in preventing international students from accessing training at RCS. For instance, in some medical schools like the University of Melbourne and UNSW international students were ineligible for RCS bursaries and subsidies [53-55], Additionally, the University of Melbourne charges Internationals almost double for accommodation at RCS[56]. Moreover, the University of Western Australia only allows internationals to apply after domestic students have, while UNSW and UQ do not allow international students to apply for rural placements at RCS[53]. These examples provide the challenges International Students face at some medical schools, whilst at other institutions they are not considered for RCS at all.

The most significant barrier to International students entering RCS is the systematic exclusion of international students from training at RCS due to lack of Commonwealth funding and requirements [26]. This is despite evidence suggesting that the longitudinal training of medical students within RCS and rural communities have better outcomes for long term rural retention [57]. With the conflicting prioritisation of domestic medical students for intern positions, and the ten-year moratorium which expects international students to fill districts of workforce shortages, international medical students are often left with rural positions that they were never exposed to or trained in, contributing to lower rates of rural retention[58].

Access to Indigenous health through RCS

There is a high proportion of rural and remote Australia who identify as Aboriginal and Torres Strait Islanders [59]. These populations often have complex health issues and higher rates of chronic illness, of which demands holistic and high quality care [59, 60, 61]. Exposure as a student to placements in Aboriginal and Torres Strait Islander health in rural and remote settings can influence career choice [61]. Often Aboriginal Community Controlled Health Organisations [ACCHO][62] are central in delivering healthcare services to regional, rural and remote Aboriginal communities, and often act as placement settings for medical students.

Students often report strong interest in Indigenous health but do not believe themselves adequately educated or prepared to work in Indigenous communities [63]. Interest in Indigenous health from students at RCS has steadily increased from 15%, in 2015, to 49% of students expressing an interest in 2020 [59]. It is therefore crucial for RCS to capitalise on these positive attitudes and support students by having opportunities for experiential learning of Indigenous health in clinical settings such as local ACCHO [62].

Efforts to recognise the inadequacies in medical education about Indigenous Australian people and the need to provide equitable services and improved health outcomes is essential [63]. However, measures need to be critically evaluated to avoid pathologising stereotypes [63], paternalistic overtones, and reductionist explanations[64]. RCS must embrace culturally respectful health care [65] and ensure that prior to placement strategies such as cultural sensitivity modules are implemented[66] prior to going on placement in an Indigenous Health capacity.

As regional and rural areas have the more robust Indigenous health infrastructure, RCS are the prime candidates to deliver Indigenous Health that improves students' knowledge of racism, cultural awareness, the complexity of social determinants and the desire to work in Aboriginal health settings in the future[66]. It is paramount to note the culturally safe aspect of ACCHO [67] and thus the importance of screening students for these placements based on their desire to work in Indigenous health and their prior understanding of Indigenous health, knowing the inextricable need for sensitivity in ACCHO. Another experience RCS can offer includes following Aboriginal Healthcare Workers in mainstream medical clinics and hospitals as a less intrusive, culturally safe clinical option for RCS to adopt.

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Policy Details

Name: Rural Clinical Schools (2021)

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