

Policies of the Australian Medical Students' Association Limited

ACN 079 544 513

CURRENTLY UPDATING NOVEMBER 2007

CONTENTS

1. Australian Medical Students' Association

- 1.1. AMSA Convention
- 1.2. AMSA Council
- 1.3. AMSA Publications
- 1.4. AMSA Representation
- 1.5. Relationship with Other Organisations
- 1.6. Membership Within IFMSA
- 1.7. State AMSA Committees
- 1.8. AMSA Executive
- 1.9. AMSA Secretariat

2. Registration of Medical Students

3. Financial Issues

- 3.1. Government Financial Support (Common Youth Allowance)
- 3.2. Union Fees for Clinical Students
- 3.3. Course Fees for Medical Studies
- 3.4. Full Fee Paying Medical Degrees

4. Infectious Diseases and Immunisation

5. Medical Education

- 5.1. Entry
- 5.2. Communication skills
- 5.3. Clinical Teaching and Prevocational Training
- 5.4. Medical Course Progression

- 5.5. New Medical Schools
- 5.6. Graduate Medical Degrees
- 5.7. First Aid
- 5.8. Women in Medical Education
- 5.9. Information Technology and Medical Education
- 5.10. Anonymous Assessment
- 5.11. Local Quotas for Medical Students
- 5.12. Clinical Education
- 5.13. Teaching Doctors
- 5.14. Rural Clinical Schools
- 5.15. Quality in General Practice Rotations
- 5.16. Increased Student Numbers
- 6. Medical Student Health and Wellbeing**
 - 6.1. Counselling
 - 6.2. Responsible Drinking
 - 6.3. Smoking
- 7. Public Health**
 - 7.1. Indigenous Health
 - 7.2. Health Care System
 - 7.3. Rural Health
- 8. Workforce Issues**
 - 8.1. Career Medical Officers
 - 8.2. General Practice Training
 - 8.3. Internships
 - 8.4. Postgraduate Training
 - 8.5. Overseas Trained Doctors and Temporary Resident Doctors
 - 8.6. Part-Time Training
 - 8.7. Restriction of the Workforce
 - 8.8. Employment of Medical students
 - 8.9. Retirement of Doctors
 - 8.10. Code of Practice
 - 8.11. Physician Assistants

9. **Sponsorship**

9.1. General

9.2. Conflict of Interest

9.3. Exclusivity

9.4. Advertising

9.5. Pharmaceutical Sponsorship

1. Australian Medical Students' Association

1.1. AMSA Convention

1.1.1. At AMSA Convention

- 1.1.1.1. Information regarding the dangers of excessive consumption of alcohol should be included in the Convention showbag. (4/98)
- 1.1.1.2. Reduced registration costs should be provided for delegates who register without drinks being included. This should be differentiated as "registration" and "registration with drinks". (4/98)

1.1.2. Common Week of Holidays

- 1.1.2.1. AMSA supports the retention of the Australian Vice Chancellor's Common Week of holidays in July of each year. (9/98)
- 1.1.2.2. AMSA encourages medical schools to ensure that teaching in Australian Medical Schools does not encroach on the common week on the grounds that it adversely affects the ability of students to participate in AMSA Convention and other extracurricular activities conducted during this week. (9/98)

1.1.3. Lap of the Map

- 1.1.3.1. A candidate for the Lap of the Map award must be a medical student at an Australian medical school, and must have attended all or part of AMSA Convention in each state of Australia in consecutive years. (9/98)
- 1.1.3.2. AMSA Council will vote on each candidate nominated. (7/91)

1.1.4. Medal of Honour

- 1.1.4.1. A candidate for the Medal of Honour award must be a medical student at an Australian medical school, and must have attended all or part of AMSA Convention during each year of the medical degree. (7/97)
- 1.1.4.2. A person nominated for the Lap of the Map is not eligible for the Medal of Honour award. (7/97) AMSA Council will vote on each candidate nominated. (7/97)
- 1.1.4.3. The content of the AMSA Convention Handbook should be checked and approved by AMSA Executive prior to publication, to prevent the inclusion of items which are not in accordance with AMSA's policies. (9/97)
- 1.1.4.4. The AMSA Convention Handbook shall include guidelines on AMSA's responsible drinking policy, and the consequences of irresponsible drinking.

1.2. AMSA Council

1.2.1. President's Award

1.2.1.1. Each year the President may nominate to AMSA Council someone deemed worthy of the President's award. (9/98)

1.2.1.2. The nominee need not be a medical student but must have significantly progressed AMSA policy or contributed significantly to issues affecting medical students. (9/98)

1.2.1.3. The nominee must be approved by AMSA Council. (9/98)

1.2.1.3.1. The award shall not be of significant monetary value, but rather a token of appreciation. (9/97)

1.3. AMSA Publications

1.3.1. Any advertising accepted by AMSA in the form of a petition, not in line with AMSA policy, must carry a bold-faced warning: "The opinion contained in this advertisement is not necessarily the opinion of AMSA". (4/98)

1.4. AMSA Representation

1.4.1. AMSA affirms its position as the peak representative body of Australian medical students. (9/93)

1.4.2. AMSA Members' Attendance at Conferences

1.4.2.1. A student attending, or obtaining funding to attend, a conference or workshop, as a representative of AMSA, must have the prior approval of the AMSA executive. (9/98)

1.4.2.2. A student attempting to obtain funding for a proposed event or project, as a representative of AMSA, must comply with the following guidelines:

- i. Any proposed event or project must be endorsed by the AMSA Executive and/or Council.
- ii. Proposed sponsors be approved by AMSA Executive and/or Council.
- iii. The level of AMSA sponsorship shall be determined by AMSA Executive and/or Council. (9/98)

1.4.3. Asian Medical Students' Conference

1.4.3.1. Any medical student at an Australian medical school may apply to attend the Asian Medical Students' Conference (AMSC). (9/98)

1.4.3.2. The criteria of selection and attendance are set out in the Regulations and By-Laws of the Association. (7/93)

- 1.4.3.3. Any AMSA Delegate to AMSC must attend for the full extent of the conference.
(7/97)

1.5. Relationship with Other Organisations

- 1.5.1. AMSA affirms its support for the AMA as a major representative organisation of the medical profession in Australia. (9/93)

1.6. Membership Within IFMSA

1.6.1. General

- 1.6.1.1. That the AMSA Council support the ongoing membership of AMSA within IFMSA.
- 1.6.1.2. That the AMSA Council support the AMSA Executive in establishing further subcommittees within IFMSA.
- 1.6.1.3. That AMSA Council support AMSA having a presence at the IFMSA conferences and financially support this.
- 1.6.1.4. That AMSA make a financial commitment to continued participation within IFMSA.
- 1.6.1.5. That AMSA seek additional sponsorship to fund sending AMSA representatives to IFMSA meetings.

1.6.2. SCOPE

- 1.6.2.1. That the AMSA Council supports the concept of a national medical student body under AMSA that deals with the health of developing communities.

1.7. State AMSA Committees

- 1.7.1.1. That AMSA supports the concept of state based medical student committees and that they should be affiliated with AMSA to an as yet to be determined extent. (9/04)

1.8. AMSA Executive

- 1.8.1.1. That AMSA should encourage and support AMSA Executive members in carrying out their roles fulltime. (9/04)
- 1.8.1.2. That AMSA should make amendments to its Memorandum and Articles of Association to make it clear that AMSA may financially support its office bearers in undertaking their positions. (9/04)

1.9. AMSA Secretariat

- 1.9.1.1. That the AMSA Council directs the AMSA Executive to seek resources to establish a permanent secretariat. (9/04)

- 1.9.1.2. That the permanent secretariat should be established at the federal AMA contingent on their support. (9/04)
- 1.9.1.3. That this establishment of a permanent secretariat be seen as a priority of both the 2004 and 2005 Executive. (9/04)

2. Registration of Medical Students

2.1. AMSA recognises the potential value of registration of medical students, with the appropriate state medical board, in maintaining high standards of medical practice. (9/98)

2.2. Purpose of Registration

2.2.1. AMSA considers the purpose of medical student registration to be as follows:

- i. to facilitate early detection of impairments that would compromise patient welfare
- ii. to encourage impaired students to seek treatment and ongoing support, where appropriate, thereby increasing the likelihood of better outcomes for the student concerned
- iii. to facilitate and encourage alternative arrangements within medical schools that allow disabled or impaired students to complete the medical degree
- iv. to minimise risk to patients, thereby protecting the public
- v. to develop an impartial mechanism of notification and investigation of complaints against students that is independent of the university
- vi. to allow recognition of medical students by any public hospital, teaching and non-teaching, in that state (10/00)

2.2.2. AMSA believes that the state medical board should only initiate investigations if it believes that the ability of a registered medical student to have direct patient contact may be affected because:

- i. of the physical or mental health of the student; or
- ii. the student has an incapacity; or
- iii. the student has exhibited unethical conduct.
- iv. Under no other circumstances should the state medical board investigate a student. (10/00)

2.2.3. AMSA believes that, in most circumstances, complaints about a medical student should only be made to a state medical board when all other appropriate avenues have been exhausted. (10/00)

2.2.4. AMSA believes that medical student registration should be a passive process, such that the medical boards only have the right to investigate a student in the event of a complaint. (10/00)

2.3. Process by which requirement to be registered is introduced

- 2.3.1. AMSA believes that medical student registration should only be introduced by way of a thorough, consultative process, culminating in endorsement from the local medical student society(ies), the medical faculty(ies) and representatives of the medical profession. (10/00)

2.4. Terms of registration

- 2.4.1. AMSA believes that the medical boards should not charge for medical student registration, or for any investigation, counselling or appeal. (10/00)
- 2.4.2. AMSA believes that it is the responsibility of each state medical board to inform all medical students registered with that board of all rights and responsibilities provided for by the Act of State Parliament under which such registration has been made, and by any amendment to such act. (9/98)
- 2.4.3. AMSA believes that all measures must be taken to ensure the absolute confidentiality of matters relating to medical student registration. In particular, the state medical board must not publish the personal data of medical students in that part of the register open to the public. (10/00)
- 2.4.4. AMSA believes that the state medical board must, as part of implementing medical student registration, develop an appeals process by which a student can appeal a decision of the board. The appeals process should have no cost to the student associated with it. The board should provide appropriate support, legal and otherwise, to students wishing to make an appeal. (10/00)
- 2.4.5. AMSA believes that students should have to provide only the following information to the state medical board for the purposes of registration:
- i. Name
 - ii. Address
 - iii. University and year level
 - iv. Specifically, students should not have to provide health status or GP reports as a condition of registration. (10/00)
- 2.4.6. AMSA believes that the state medical board must not make professional indemnity insurance a condition of registration as a medical student. (10/00)

2.5. Transferability of registration

- 2.5.1. AMSA believes that registration with one state's medical board as a medical student should be recognised by all other states' medical boards. (10/00)
- 2.5.2. AMSA believes that a student from a state in which registration as a medical student is not required who wishes to undertake a component of clinical studies in a state in which registration is required should not be required by the latter state's medical board to apply for temporary registration. (10/00)

3. Financial Issues

3.1. Government Financial Support (Common Youth Allowance)

- 3.1.1.1. AMSA recognises that tuition and living costs are a substantial barrier to access to tertiary education. AMSA believes that the Government should provide an appropriate level of financial support for students requiring it, for the full duration of their medical education. (7/98)
- 3.1.1.2. AMSA supports the granting of the Common Youth Allowance or Austudy to medical students who have completed all or part of an undergraduate degree, particularly where having such experience is an accepted means of admission to a medical degree. (7/98)
- 3.1.1.3. AMSA supports policies which ensure that financial, social and geographic factors do not act as a barrier to higher education for appropriately qualified students. (7/98)
- 3.1.1.4. AMSA supports medical students enrolled in Graduate Entry Medical Courses having the same access to the Common Youth Allowance or Austudy as medical students enrolled in Undergraduate Entry Medical Courses. (7/98)
- 3.1.2. AMSA encourages Medical Faculties to develop course classifications that ensure all medical students have the same access to the Common Youth Allowance or Austudy as other students, particularly where the medical course is subsequent to previous studies. (7/98)

3.2. Union Fees for Clinical Students

- 3.2.1. AMSA opposes the compulsory payment of full union fees for clinical students off campus. (9/93)
- 3.2.2. AMSA calls for union fees for medical students off campus to be distributed back to these medical students via their representative organisation(s). (3/96)

3.3. Course Fees for Medical Studies

- 3.3.1. AMSA opposes the charging of fees for compulsory course items, on the grounds that it is illegal under the Higher Education Funding Act 1988 s104(2), and that it discriminates against financially disadvantaged students. (4/95)

3.4. Full Fee Paying Medical Degrees

- 3.4.1. AMSA believes that (2/07):
 - i. Every Domestic Undergraduate Full-Fee paying medical student in Australia is a member of the organisation and has its full support.

- ii. Domestic Undergraduate Full-Fee paying medical students are no different from Commonwealth Supported students in their potential to become skilled and competent practitioners.
 - iii. Domestic Undergraduate Full-Fee paying students deserve the same opportunity to undertake an internship as Commonwealth Supported students.
 - iv. Domestic Undergraduate Full-Fee paying students deserve more financial support than they are currently receiving and, as such:
 - a. The costs of medical degrees should be reduced wherever possible.
 - b. The 20% fee-loading on the Commonwealth Fee-HELP scheme should be removed.
- 3.4.2. AMSA believes that (2/07)
- i. There should be equity of access to all Domestic Undergraduate Full-Fee paying medical places and that:
 - a. Domestic Undergraduate Full-fee places are exorbitantly expensive
 - b. Not all prospective medical students have the financial capacity to access Domestic Undergraduate Full-fee places.
 - c. The cost of a Domestic Undergraduate Full-Fee paying medical degree can be a significant burden for the full-fee paying student and their family.
 - ii. The health care of all Australians should be considered important enough to warrant Government financial subsidy for all domestic medical places
 - iii. Money received from Domestic Undergraduate Full-fee paying students in medicine should not disproportionately contribute to general university revenue.
 - iv. Financial stress may have negative physical and mental health effects on Domestic Undergraduate Full-Fee students.
 - v. Debt incurred through completing a Domestic Undergraduate Full-Fee paying degree may influence choice of specialty and work location in a way that may not address current workforce shortages.
 - vi. Ideally, all domestic medical places would be Commonwealth Supported.
 - vii. Given the ongoing existence of Domestic Undergraduate Full-fee places, every attempt should be made to make these places more affordable.

- 3.4.3. In the interests of maintaining equity of access to medical education in Australia, AMSA calls on the Deans of the Medical Schools to oppose the introduction of up-front fees or full fee charges for students who are citizens and permanent residents of Australia. (7/98)
- 3.4.4. AMSA encourages all medical schools with full-fee paying places for domestic students to implement scholarships and bursaries wherever possible to assist students from a broad variety of backgrounds in affording the cost of their medical degree, thus improving equity of access. (6/04)
- 3.4.5. That AMSA supports all medical students enrolled in private medical educational institutions and that these students should not have to pay upfront fees, full fees or any course fee above the set HECS fee; furthermore these students are welcome to participate and contribute fully to AMSA. (9/04)
- 3.4.6. That AMSA continues to have concerns about private medical educational institutions for the following reasons:
- i. concerns regarding equity of access to private medical schools
 - ii. an increased emphasis on one's financial capacity in selection procedures, and the potential for this to overshadow criteria relating to academic merit, ability and personality;
 - iii. the impact that any increase in medical student debt (incurred by students paying full-fees at such institutions) would have on graduating doctors and Australia's healthcare system, leading to a change in demographics and motivation for doctors' participation in the system;
 - iv. the potential limited experience gained by students from exposure to only private hospitals and teaching facilities;
 - v. a potential entrepreneurial approach to medical education, and;
 - vi. the potential to compromise the integrity of the medical profession with an increased emphasis on finances and the potential for monetary gain to override educational value.
 - vii. Such opposition is generated out of concerns for students, and a desire to protect their interests and the standing of medical education. (9/04)

3.5. Increasing The FEE-HELP (Government Loan To Full-Fee-paying Students) Cap For Full-Fee Paying Medical Degrees

3.5.1. AMSA is against any increase in the FEE-HELP cap for medical degrees on the basis that this could be construed as tacitly endorsing a system which AMSA opposes. (9/04)

4. Infectious Diseases and Immunisation

- 4.1. AMSA endorses the NH&MRC and ANCA Joint statement on testing of health care students for HIV and Hepatitis B. (9/96)
- 4.2. AMSA believes no student should be discriminated against on grounds of disease status. (9/96)
- 4.3. AMSA opposes the compulsory HIV, hepatitis B and hepatitis C testing of medical students on the basis that the results may be used for discrimination or vilification. (9/96)
- 4.4. AMSA supports the rights of all medical students to confidentiality regarding HIV, hepatitis B and hepatitis C status. (9/96)
- 4.5. AMSA believes all medical students have a responsibility be aware of their own infective status, and to understand and practise universal precautions. (9/96)
- 4.6. AMSA believes all medical students should have access to appropriate vaccination programmes, and that the cost of such vaccinations should not be borne by the students. (9/96)
- 4.7. AMSA advises enrolling medical students with known HIV or hepatitis B or C carrier status to seek counselling regarding career choice. (9/96)
- 4.8. AMSA holds that medical students, regardless of their infective status, be allowed to complete their degree despite being limited from participation in exposure prone procedures. (9/96)
- 4.9. AMSA recognises that there is no general legal obligation for students to inform their medical schools of their HIV/HBV/HCV status; however, AMSA believes that students should do so in order to ensure their welfare and safety in the workplace be maximised and so they fulfil the common law duty of care to safeguard patients. (7/93)
- 4.10. In the absence of patient exposure to potentially infected material, AMSA believes that students have no obligation to inform patients of their HBV/HCV/HIV status considering that there is no onus of confidentiality on the patients part. (7/93)
- 4.11. AMSA believes that the minimum level of immunisation and screening services that should be offered by the Australian Medical Schools are as follows:
 - i. Testing for HBV, HCV and HIV.
 - ii. Vaccinations against HBV, tetanus, polio, measles, mumps and rubella.
 - iii. Continuous Mantoux testing and/or BCG. (7/97)
- 4.12. AMSA recommends the following Student Infectious Disease Action List:

- i. Read and adopt the recommended practices concerning infection control and universal precautions as provided by your faculty or clinical school.
- ii. Review your routine childhood immunisation status. Diseases of concern include tetanus, diphtheria and polio. You can update your immunisation status at your University Health Service or family doctor.
- iii. Make arrangements to ensure you are vaccinated against hepatitis B.
- iv. Have a Mantoux test to check your tuberculosis status, and be vaccinated against tuberculosis if necessary.
- v. Seek advice from your hospital Occupational Health Department, University Health Service or family doctor if you are exposed to infections against which you are unlikely to be immune, or plan to work amongst patients who might be particularly susceptible to that infectious agent.
- vi. Regularly review your immune status for HIV and hepatitis B.
- vii. Should you, in the course of your studies, have a work-related accident with risk of infection (e.g. needle stick injury), you should report immediately to your hospital's Occupational Health department or, if after hours, Accident & Emergency. (7/97)

5. Medical Education

5.1. Entry

- 5.1.1. AMSA believes a broad range of entry criteria to medical courses around Australia will be beneficial in producing a diverse future medical workforce reflective and responsive to the demands of Australian society. (7/98)
- 5.1.2. AMSA believes special consideration should be given to sections of the Australian population who have reduced access to medical education. These equity groups include Aboriginal and Torres Strait Islanders, socio-economically disadvantaged groups and rural students. (7/98)
- 5.1.3. UMAT Training Courses (10/07)
 - 5.1.3.1. AMSA believes commercial UMAT training courses undermine an admissions test that purports to standardise the entry process to medical school. AMSA believes the UMAT training process does not set an appropriate tone for the commencement of studies in medicine.
 - 5.1.3.2. AMSA has specific concerns regarding the UMAT training industry:
 - i. The quality and integrity of the courses cannot be verified.
 - ii. The cost of these courses is substantial.
 - iii. The industry does not promote equity of access; there is limited cost-effective training available to rural and remote origin students.
 - iv. Providers are fiercely competitive and operate in an unregulated commercial environment.
 - v. Claims of effectiveness by course providers conflict with ACER's position that training is not beneficial.
- 5.1.4. AMSA suggests the following actions to address these concerns:
 - i. ACER undertakes to increase the rate at which it turns-over course material.
 - ii. Medical Deans and the Federal Government consider mechanisms to regulate training providers.
 - iii. ACER initiates a formal study into the impact of commercial UMAT training courses on test outcomes.

- iv. ACER produces more comprehensive resource materials for students undertaking the UMAT.

5.2. Communication skills

- 5.2.1. AMSA believes that communication skills are essential in the doctor-patient relationship. (7/98)
- 5.2.2. AMSA holds that communication skills can be taught, and should hold a prominent position in medical curricula. However, AMSA recognises that an assessment of level of competency in communication skills may be an appropriate requirement for entry. (7/98)

5.3. Conclusion of the medical degree

5.3.1. National Licensing Exams

- 5.3.1.1. AMSA supports the current Australian Medical Council accreditation program for Australian medical schools, in the belief that it ensures a uniform standard of medical education, whilst allowing for diversity among medical schools. (9/00)
- 5.3.1.2. AMSA opposes any moves to introduce national licensing exams, in the belief that they would limit the diversity that currently exists among the teaching styles and curricula of Australian medical schools. (9/00)

5.3.2. Pre-internship

- 5.3.2.1. AMSA believes that the focus of any pre-internship period should be as broad as possible, and should incorporate the acquisition of procedural and other skills beyond those required to function as an intern. (9/00)
- 5.3.2.2. AMSA believes that specific training to work as an intern should occur at the start of the intern year, and not as part of the medical degree. (9/00)
- 5.3.2.3. AMSA does not support calls for pre-internships to be introduced in all Australian medical schools, in the belief that there should be diverse styles of clinical education. (9/00)
- 5.3.2.4. AMSA rejects any pre-internship that requires medical students to work as unpaid interns. (9/00)

5.3.3. Final-year Barrier Exams

- 5.3.3.1. AMSA rejects calls for the removal of barrier exams from the final year of the medical course at all Australian medical schools, in the belief that there should be diverse styles of clinical education and assessment. (9/00)

5.4. Medical course progression

5.4.1. AMSA believes that, once a student has entered a given medical course, the medical school should not alter the rules of progression or eligibility criteria for progression applicable to that student. (7/96)

5.5. New Medical Schools

5.5.1. AMSA believes that any proposal for a new medical school should only result in an increased total number of Australian medical graduates if there is:

- i. evidence that the medical workforce in Australia requires augmentation; and
- ii. a concomitant increase in the number of postgraduate medical specialty training places. (05/01)

5.5.2. AMSA believes that any new medical school should only be established after detailed planning for selection procedures, academic and clinical staffing, and the entire course curriculum. (05/01)

5.5.2.1. AMSA believes new medical schools should only be established if there is evidence that similar outcomes could not be achieved by increasing the intake at existing medical schools. (05/01)

5.5.2.2. That AMSA expresses concern at the rapid increase in the number of new medical schools and the level of workforce planning that has preceded their establishment. (9/04)

5.5.2.3. That AMSA calls upon the government and related organisations to ensure that wider consultation and extensive workforce planning is undertaken prior to the establishment of any new medical schools. (9/04)

5.5.3. Membership Within AMSA

5.5.3.1. That AMSA, as the association for all medical students in Australia, should extend an invitation to all medical schools in Australia to provide an elected representative of their school to sit on AMSA Council. (6/04)

5.5.3.2. That AMSA believes in representing and supporting medical students regardless of the medical institution at which they study.

5.5.4. Establishment of Medical Student Societies

5.5.4.1. The AMSA Council directs the AMSA Executive to assist medical students at all new medical schools in establishing medical student societies on the basis that such

societies are a vital means by which to support and enhance the lives of medical students. (6/04)

5.6. Graduate Medical Degrees

- 5.6.1. AMSA is concerned by the disadvantages which may be experienced by students in the final years of the undergraduate degree at medical schools transferring to a Graduate Medical Course, owing to the development of the graduate curriculum at the possible expense of teaching and quality assurance in the undergraduate degree, and believes that adequate mechanisms should be in place to maintain teaching quality in the undergraduate degree whilst the graduate format is being developed. (7/94)
- 5.6.2. AMSA is concerned by the potential overload of hospital teaching resources which may occur during the changeover period, during which time students in both degree formats will require clinical teaching. AMSA believes that adequate consideration of this must be included in the planning of the graduate degree. (7/94)

5.7. First Aid

- 5.7.1. AMSA Council believes that First Aid teaching (outside any Accident and Emergency Term) should be compulsory at all Australian Medical Schools due to the justifiable expectations that the public has of students' and doctors' abilities to save lives in an emergency situation. (9/95) (Reaffirmed 2/04)
- 5.7.2. AMSA Council believes that the minimum requirement for First Aid teaching should be the Senior First Aid Certificate, or equivalent, and that this should be taught to students in the first year of the course, with a revision course being conducted in the clinical years of the course. (9/95)
- 5.7.3. AMSA Council believes that this training, if not conducted by the University, should not result in an expense to any student, except where such an expense is incurred in the purchase of non-compulsory course items. (9/95) (Reaffirmed 2/04)

5.8. Women in Medical Education

- 5.8.1. AMSA seeks to address gender bias within the medical education system by:
- i. Promoting equality between male and female medical students and practitioners in all areas. (4/94)
 - ii. Increasing the awareness of all students to inequalities present in medical education and the medical workforce. (4/94)

- iii. Monitoring the introduction of graduate degrees with respect to possible detrimental effects on female students. (4/94)
 - iv. The provision of appropriate role models to female medical students. (4/94)
 - v. Promoting awareness of the appropriate avenues of redress for sexual harassment and discrimination. (4/94)
 - vi. Abolishing sexist language and material in all AMSA activities and publications. (4/94)
 - vii. Support for and communication with organisations having similar aims. (4/94)
 - viii. Promoting awareness that gender specific language is inappropriate. (7/96)
- 5.8.2. AMSA believes that the proportion of women speakers at AMSA Convention should be representative of the proportion of female medical students. (7/96)
- 5.8.3. AMSA encourages seminars which specifically address the issues set out in this "Women in Medical Education" Policy, and supports the inclusion in the Convention Academic Programme of these issues, and other issues relevant to women's health and women in medicine. (7/96)
- 5.8.4. AMSA supports articles in Antics which raise awareness of the issues set out in this Women in Medical Education Policy. (7/96)
- 5.8.5. AMSA calls on medical faculties to be aware of issues facing medical students such as finding or financing child care, especially with on-call work and current timetable structures. (7/96)
- 5.8.6. AMSA endorses the development of medical curriculum policy to address relevant issues including assertiveness training and practice management (7/96)
- 5.8.7. A member of the Executive will be responsible for the institution of the Women in Medical Education Policy (7/96)

5.9. Information Technology and Medical Education

- 5.9.1. AMSA supports the integration of information technology and computer-aided learning into Australian medical curricula. (9/98)
- 5.9.2. AMSA supports equal access for all medical students to adequate information technology facilities for the purposes of coursework. (9/98)
- 5.9.3. AMSA opposes the sole use of electronic communication for transmission of faculty and course information in circumstances where medical students do not have universal adequate information technology facilities. (9/98)

5.10. Anonymous Assessment

5.10.1. That AMSA supports the use of anonymous assessment wherever practical on the basis that it removes any potential positive or negative bias in the marking of medical students. (2/04)

5.11. Local Quotas for Medical Students

5.11.1. That AMSA is opposed to binding local quotas for any Australian medical school because a local quota would act to compromise equity of access and diversity within Australian medical schools;

5.11.2. AMSA supports equity of access to medical schools and a nation-wide diversity of students within them.

5.11.3. That AMSA believes that infrastructure, salary, enterprise bargaining agreements, post graduate training opportunities, hospital working conditions and lifestyle factors all play an important role in the decision making of junior doctors when choosing a workplace.

5.11.4. That AMSA believes that state departments of health must address all these issues before considering the implementation of a local quota.

5.12. Clinical Education

5.12.1. That AMSA believes that clinical education in Australia has been compromised by increased pressure upon teaching doctors to deliver quality health care to patients as well as quality teaching to medical students. (6/04)

5.12.2. That AMSA believes that improved clinical education for medical students will result in better patient outcomes and community health. (6/04)

5.13. Teaching Doctors

5.13.1. That AMSA calls upon hospital administrators and state departments of health to support quarantined teaching hours for all doctors who teach medical students. (6/04)

5.13.2. That AMSA values the huge contribution that doctors make to medical education and calls upon medical student societies to implement initiatives that formally recognise the contribution of teaching doctors. (6/04)

5.14. Rural Clinical Schools

5.14.1. See also 7.3 Rural Health

5.14.2. AMSA recognises that medical education in the rural setting has many benefits, and as such is broadly supportive of the concept of rural clinical schools. (6/01)

5.14.3. It is AMSA's belief that, in providing the option of a rural clinical school, medical schools have a duty of care to their rural-based students to ensure that they are in no way

- disadvantaged when compared to their urban-based counterparts. In particular there must be guarantees that the quality of the education offered by a rural clinical school is at least commensurate with that provided in urban centres. (6/01)
- 5.14.4. AMSA believes that no student should be coerced into attending a rural clinical school. Instead positive incentive programmes should be developed and promoted until all places are filled. (6/01)
- 5.14.5. It is AMSA's view that accommodation for medical students at RCS should be free of charge. This will not always be practical, and where this is the case efforts need to be taken to subsidise it as much as possible. (6/01)
- 5.14.6. Many medical students rely on paid employment to finance their way through medical school. Ideally, rural clinical schools would set up employment programs for their students, with the support and assistance of local community business groups. In those cases where it can be shown that the demand for employment outweighs the supply, other sources of financial support for students will need to be developed, such as bursaries. (6/01)
- 5.14.7. AMSA believes that medical schools should attempt to minimise or eliminate the costs associated with travel between the RCS site and the medical school and urban centre. Measures that could be used to achieve this include subsidising trips between the two sites to an agreed number of times e.g. 1 trip per month and at the very least paying for the initial trip and final return leg and working towards minimising the number of times a rural clinical school student has to travel back to the base medical school (e.g. by arranging for examinations to be administered locally). In terms of travel requirements at the rural clinical school itself, the accommodation must be located close enough to the school to preclude the need for a car, or if this is not possible consideration for providing use of a car on a limited basis is merited. (6/01)
- 5.14.8. It is unreasonable to expect a new rural clinical school to have the same educational resources as a well-established city clinical school; however, every effort must be taken to ensure that rural clinical students are not disadvantaged as a result. The increasing availability of educational resources in electronic form should go some way towards minimising this potential disadvantage, and so it is vital that rural clinical students have access to as wide a range of IT services as possible. (6/01)

5.14.9. Active steps must be taken concomitantly with the development of the RCSs to ensure that the graduates they produce have reasonable opportunities for and access to internships and postgraduate medical specialty training in rural areas. (6/01)

5.15. Quality in General Practice Rotations

5.15.1. With an increasing number of medical students, AMSA believes it will be necessary to broaden the scope of clinical teaching to include alternative learning environments, including a greater emphasis on general practice (GP).

5.15.2. AMSA believes that it is imperative that the learning experience in general practice is optimised to match the expectations of medical students, GP clinical teachers and medical schools alike.

5.15.3. AMSA believes the following principles form the basis of a positive GP placement experience for senior medical student

5.15.3.1. To ensure appropriate introduction to the General Practice Rotation

5.15.3.1.1. The Medical School should:

- i. Provide an introductory lecture immediately prior to the GP rotation, addressing several key areas such as GP as a specialty, course components and curricular requirements, recommended resources and assessment.
- ii. Encourage students to meet with their GP clinical teacher to discuss and formulate shared learning objectives for the rotation.
- iii. Provide students with information about support programs that may be relevant to their placement.
- iv. Guarantee students with appropriate indemnity to cover their GP rotation.

5.15.3.1.2. The GP Should:

- i. Provide a comprehensive introduction to the practice (and hospital if applicable), any specialist services provided (e.g. Obstetrics), the practice staff and the general running of the practice itself.
- ii. Introduce the student to the use of the practice's (and hospital's if applicable) IT network in addition to local pathology and radiology systems.

- iii. Identify with the student, their desired level of involvement with patients, be it observational, conducting interviews under supervision or seeing patients in an individual consulting room
- iv. Review the student's key learning objectives, as referred to in 3.1.3i, with the intention of reviewing these at a later date.

5.15.3.1.3 The Medical Student Should:

- i. Seek to identify their own interest areas of GP and their specific personal learning objectives
- ii. Approach their GP rotation in a positive manner, and seek to make the most of all learning opportunities
- iii. Seek to actively participate in orientation to the practice
- iv. Seek to understand administrative processes within the practice including billing and referral systems.

5.15.3.2 To ensure adequate support for the GP Clinical Teacher:

5.15.3.2.1 The Medical School should:

- i. Provide GP clinical teachers with the appropriate resources to best enhance the teaching experience, including but not limited to an orientation session with advice from experienced GP clinical teachers
- ii. Emphasise the importance of supervision in GP rotations, but stress that interactive models where the student is actively involved in the consulting process are probably most effective
- iii. Make available an easily accessible university contact for teaching-related and/or administrative enquiries
- iv. Assist the GP with information required to claim governmental incentive payments for education
- v. Actively seek means to provide sufficient remuneration for the GP clinical teachers as recognition of the time, effort and lost earnings

- vi. Recognise the efforts of GP clinical teachers by awarding them certificates of appreciation, adjunct clinical titles (where appropriate) and other academic benefits
- vii. Invite GP Clinical Teachers to provide feedback on their experience during the rotation, whether it be by correspondence or in person

5.15.3.2.2 To ensure the rotation is educationally effective:

5.15.3.2.2.1 The Medical School should:

- i. Ensure that the GP is adequately briefed on the aims of the placement and is well resourced to meet these goals
- ii. Ascertain the teaching model the facility wishes to employ and provide feedback on the model, in addition to suggestions towards interactive and stimulating placements
- iii. Provide students with the opportunity to provide feedback on their placement, their GP clinical teacher and their experience with the intention to review and act on any recommendations for change

5.15.3.2.2.2 The GP should:

- i. Inform patients of the presence of medical students in their practice, both by visible signage in addition to verbal notice by both receptionist and doctor.
- ii. Endeavour to provide adequate resources to supplement the medical student's learning environment e.g. a computer terminal with Internet access, small library, relevant journals and phone line.
- iii. Endeavour to provide a consulting room (ideally linked to the practice IT network) if students wish to consult patients individually.
- iv. Ensure senior students are given opportunities to record patient notes and discuss patient management with the supervising GP.
- v. Encourage the student to partake in as many general practice and general practice specialty activities as possible.
- vi. Make themselves available to the students as a key resource by remaining approachable, and welcoming questions from the student.
- vii. Endeavour to allocate some time for formal teaching during the course of the rotation, either during lunch breaks or in a dedicated time-slot.

5.15.3.2.2.3 The Medical Student should:

- i. Seek to actively acquire resources for learning, and to utilise the GP as a key resource
- ii. Integrate local learning infrastructure with resources external to the general practice
- iii. Be keen to engage in clinical and non-clinical general practice processes

5.16. Increased Student Numbers

5.16.1. AMSA believes that (02/07):

- i. Increases in medical student numbers are, to an extent, required to address medical workforce shortages and an ageing Australian population.
- ii. Increases in medical student numbers should occur incrementally, to ensure that the medical workforce is sufficient in number to allow appropriate student access to clinical teachers.
- iii. Any increase in the number of medical students studying in Australia should only occur with extensive prior evaluation and planning of educational and clinical resources, to ensure the quality of medical education is maintained.
- iv. It is the responsibility of all stakeholders in medical education, including but not limited to Australian medical schools, the AMC and state and federal governments, to demonstrate that a sufficient number of appropriate clinical places are available to students.
- v. Despite increases in medical student numbers, all students of Australian medical schools must have sufficient exposure to an extensive range of medical specialties and clinical settings including, but not limited to, public and, where appropriate, private hospitals; rural clinics; community health care facilities; and general practice.
- vi. In the face of increasing student numbers, clinical simulators may be useful in the delivery of medical education but that patient contact and tutelage from clinicians must remain the cornerstone of medical education.
- vii. Students should be involved in the consultative and decision making process towards the accommodation of increased student numbers.
- viii. Consistent with Section 8 of AMSA Policies (Revision 2001), in the setting of a workforce shortage, the number of available medical internships should be commensurate with the projected number of medical graduates; otherwise the imperative for increasing student numbers is not met.

- ix. Solutions, that maintain the quality of education, must be sought to alleviate the potential bottleneck for entry into vocational training, before the increased numbers of students reach this point in their careers.

6. Medical Student Health and Wellbeing

6.1. Counselling

- 6.1.1. AMSA recognises the need for adequate counselling for medical students and supports efforts to ensure its implementation. (9/95)
- 6.1.2. AMSA believes that counselling should be readily accessible to all medical students and that this counselling should be provided by a qualified counsellor who has a knowledge of the medical course, but who is not directly involved in student examination or academic supervision. (9/95)

6.2. Responsible Drinking

- 6.2.1. AMSA supports the concept of responsible drinking and holds that events it promotes should be organised in a way which discourages binge drinking and dangerous levels of consumption. (7/96)
- 6.2.2. At all AMSA functions where alcohol is to be consumed: non-alcoholic drinks must be as readily available and cheaper than alcoholic beverages; water must be available in plentiful quantities and free of charge; reasonable quantities of food must be readily available. (7/96)
- 6.2.3. As far as possible, AMSA events should not be structured such that patrons who do not wish to drink subsidise the cost of alcohol for other patrons. (7/96)
- 6.2.4. Organisers of any AMSA events are required by law to refuse further service to any patron considered to be too intoxicated, irrespective of any payment received from that person. (7/96)
- 6.2.5. Where possible, drinks should be provided in the form of 'standard drinks', that is drinks containing 10g alcohol (300 ml beer, 30ml spirit, 100ml wine) in order to best enable patrons to monitor their intake. Where this is not done, information about converting drinks provided to standard drinks should be made available. (7/96)
- 6.2.6. Organisers of events should consider known co-morbid factors associated with alcohol consumption such as drink driving and unsafe sex, and should consider methods of preventing these. Designated driver programmes are welcomed by AMSA. (7/96)

6.3. Smoking

- 6.3.1. At AMSA organised functions:
 - i. Tobacco advertising and vending facilities should not be present within the venue.

- ii. Adequate ventilation must be ensured.
 - iii. Smoking is banned within the venue. (9/97)
- 6.3.2. AMSA is to provide public health material on smoking and passive smoking in the Convention 'showbag' and other AMSA publications. (9/97)
- 6.3.3. AMSA condemns tobacco advertising. (9/97)
- 6.3.4. The Convention promotional material and registration form shall state that smoking is banned within venues. (9/97)

7. Public Health

7.1. Indigenous Health (6/07)

In this document the term Indigenous refers to Indigenous Australians. It is the position of AMSA that the health of all Australians both Indigenous and non-Indigenous, should be a top priority of the government and other relevant organisations and supports all efforts to improve both global and equitable health outcomes for all. This being so, AMSA believes the long-standing inequity between Indigenous and non-Indigenous health outcomes in Australia is unacceptable. AMSA believes the respect of peoples' culture, practices and beliefs is integral in the provision of good healthcare and the attainment of good health. Therefore, in delivering a healthcare package with better outcomes, AMSA recognises that the link between reconciliation and social determinants of health have a direct effect on the health of Indigenous Australians. The education of our future doctors needs to address the current disparity between Indigenous and non-Indigenous health. AMSA works to promote an understanding of the issues involved in the provision of healthcare to Indigenous Australians and seeks to become involved in improving the health of Indigenous Australians.

- 7.1.1. AMSA recognises the importance of student exposure to Indigenous health issues in medical education as being a significant way to ensure that the profile of medical graduates reflects the needs of the whole Australian community.
- i. Medical schools should provide bursaries to encourage exposure to Indigenous health care while at medical school.
 - ii. AMSA shall lobby medical schools to encourage the implementation of more placements in Aboriginal Controlled Community Health Organisations (ACCHO) to be incorporated into the curriculum.
 - iii. AMSA shall encourage the implementation for all medical students to undertake at least one placement during their degree with an ACCHO in order to promote greater understanding of the aspects Indigenous healthcare provision.
 - iv. Medical schools should develop Indigenous community attachments which are mutually beneficial to students and the communities themselves. With these attachment opportunities, appropriate preparation and support networks should be developed to maximise student outcomes and community benefit.

- v. AMSA shall award an annual prize for an essay on any aspect of Indigenous health.

7.1.2. AMSA affirms its position that a devised and integrated Indigenous Health curriculum with nationally standardised goals is important in the effective delivery of Indigenous Health education. Such curriculum includes but is not limited to:

- i. An adequate emphasis on social, cultural and medical aspects of Indigenous health.
- ii. Consideration of the principles of cultural safety (Ramsden, I. Kawa whakaruruhau: Cultural safety in nursing education in Aotearoa. Wellington: Ministry of Education. 1990)
- iii. The provision of greater opportunities for medical students to learn in Indigenous health centres.

7.1.3. In addition, AMSA recognises the important role that Indigenous doctors play in improving the health of Indigenous Australians, hence AMSA believes that:

- i. Adequate provision must be made for the admission and support of Indigenous medical students.
- ii. AMSA encourages medical schools to provide appropriate support systems for Indigenous medical students.
- iii. Medical schools should provide bursaries, scholarships and placements to Indigenous Australian students to encourage exposure to Indigenous healthcare while at medical school.
- iv. AMSA commits to fostering a relationship with Indigenous medical students of Australia and harnessing their unique perspective on Indigenous health.

7.1.4. AMSA is committed to developing, supporting and initiating projects to improve the knowledge and skills of its members in order to facilitate improved and increased interactions with Indigenous Health services, communities and patients. In doing so, AMSA will:

- i. Work to support its members who initiate Indigenous Health projects.
- ii. Develop improved networks with other organisations focused on Indigenous Health where appropriate.

- iii. Foster an ongoing commitment to Indigenous health by actively lobbying the government and other relevant organisations to put all facets of Indigenous health education on the agenda.
- iv. AMSA will regularly update its members on new developments in Indigenous health and comment on new policy where appropriate.

7.2. Health Care System

7.2.1. AMSA believes that the Australian community is entitled to a health system which is both:

- i. Accessible without unreasonable delay.
- ii. Effective - providing at the least a minimum standard of care defined by the Australian Council on Healthcare Standards. (7/97)

7.3. Rural Health

7.3.1. Rural student intake into medical courses

7.3.2. AMSA believes special consideration should be given to sections of the Australian population who have reduced access to medical education. These equity groups include Aboriginal and Torres Strait Islanders, socio-economically disadvantaged groups and rural students. (7/98)

7.3.3. Medical Curriculum

7.3.3.1. AMSA believes that in order to increase the numbers of practitioners in rural and remote areas, exposure to rural medicine in the medical curriculum should be increased. (7/94)

7.3.3.2. AMSA believes that medical students should be exposed to rural medicine in each year of their course. This exposure should be vertically integrated into the medical school curriculum. (5/00)

7.3.3.3. AMSA believes that there should be increased exposure to Aboriginal and Torres Strait Islander health in the medical school curriculum, involving Aboriginal and Torres Strait Islander Australians in curriculum design and delivery. (5/00)

7.3.4. Positive Incentives

7.3.4.1. AMSA encourages the development of positive incentives for well-supported rural medical training exposure for medical students and graduates. (7/98)

7.3.4.2. AMSA opposes any bonded scholarship that:

- i. requires a bonded student to work in a specific rural or remote area;
- ii. potentially denies students a provider number even after they have entered a training program;
- iii. does not allow students to accredit any rural postgraduate training to the period of the bond;
- iv. commits students to a bond in excess of four years;
- v. does not have adequate flexibility to accommodate changes in circumstances that were not foreseen at the time of signing the contract; or
- vi. creates a new pathway or entry standard into medical school or training programs.

7.3.5. AMSA encourages the appropriate bodies to provide study grants for students electing to complete option terms in rural and remote areas within Australia. (7/94)

7.3.6. Compulsory rural terms

7.3.6.1. AMSA believes that adequate financial support should be made available for medical students completing rural rotations as part of their curriculum. (7/98)

7.3.6.2. AMSA believes that in the interests of improving the quality of student rural experiences, any compulsory rural medical training should allow flexibility for the special needs and requirements of some students. (7/98)

7.3.6.3. AMSA supports the completion of at least eight weeks clinical experience in a rural community setting prior to completion of any medical course. (5/00)

7.3.6.4. AMSA believes that teaching sites should be assessed against national standards. (5/00)

7.3.6.5. That AMSA believes that all schools of medicine should provide GP and other medical preceptors with clear teaching guidelines, adequate support and resources to aid in the education of medical students. (5/00)

7.3.6.6. AMSA believes that every rural placement should have the following:

- i. adequate and accessible information technology for further teaching of the medical curriculum and communication with family and friends;
- ii. an accommodation provision appropriate to the needs of the student;

- iii. flexible arrangements, such that students not living with their spouse or family during the elective are allocated visiting time;
- iv. adequate supervision, such that whenever a student is involved in direct patient care, an appropriately trained health care worker is present and accessible, and a senior medical officer is within calling distance. (7/00)

7.3.7. Bonded Medical Places scheme

7.3.7.1. AMSA believes that (2/07):

- i. The Bonded Medical Places scheme is exploitative of prospective medical students by taking advantage of their desire to study medicine.
- ii. The Bonded Medical Places scheme is exploitative of prospective medical students because of the disparity between supply and demand for medical places
- iii. The Bonded Medical Places scheme will prove an ineffective way of addressing workforce shortages in areas of workforce need in the long term.
- iv. The Bonded Medical Places scheme is negatively perceived by medical students.
- v. The Bonded Medical Places scheme potentiates stigma around rural and outer-metropolitan practice, undermining the attractiveness of practice in these areas.
- vi. Other means of attracting doctors to areas of workforce need, which have been received positively by students, should be prioritized ahead of the Bonded Medical Places scheme.
- vii. Potential medical students are under-informed about the Bonded Medical Places scheme when they sign the relevant Commonwealth deed of agreement.
- viii. In a climate where the Bonded Medical Places scheme continues to exist, it would be improved if:
 - a. The scheme offered educational, social and professional incentives, such as funded conference attendance or mentoring support, to students.
 - b. The scheme was more flexible, allowing bonded doctors to fulfil their bond earlier in their careers.

7.3.8. Postgraduate medical training

7.3.8.1. Training Programs

- 7.3.8.1.1. AMSA endorses a flexible funding system, which acknowledges the potential for several providers in a single and integrated training program of uniform national standard for Australian General Practice. (4/00)
 - 7.3.8.1.2. At the vocational level, AMSA endorses the implementation of demonstrably valid and reliable admission processes that reward applicants providing evidence of current or past commitment to rural health and rural practice. (5/00)
 - 7.3.8.1.3. AMSA should investigate the extent to which rural and remote practice are incorporated into all training programs. (5/00)
 - 7.3.8.1.4. AMSA encourages those training programs whose curricula are deficient in this area of rural and remote practice to remodel relevant parts of the curriculum such that doctors-in-training are encouraged to enter rural practice. (5/00)
 - 7.3.8.1.5. Where there are rural and non-rural training streams present in medical curricula or a training program, AMSA believes that all rural and non-rural stream graduates should graduate with a uniform national standard, allowing each graduate to work in the area of his/her choice, whether it be urban or rural. (5/00)
 - 7.3.8.1.6. AMSA approves of rural training places provided that there is flexibility to interchange between rural and non-rural streams to accommodate changes in lifestyle and circumstances. (5/00)
- 7.3.9. Clinical Assistantship Program (CAP)
- 7.3.9.1. AMSA believes that the Clinical Assistantship Program (CAP) does not further the Government's aims of vocational training and ensures that rural communities are exposed to a substandard level of care as compared to their metropolitan counterparts. (5/00)

8. Workforce Issues

8.1. Career Medical Officers

- 8.1.1. AMSA supports continued student input into the development of a non specialist Career Medical Officer programme. (9/96)

8.2. General Practice Training

- 8.2.1. AMSA calls upon the RACGP to provide sufficient Royal Australian College of General Practice Training Position (RACGPTP) posts, both hospital and community based to allow unimpeded completion of the RACGPTP. (9/92)
- 8.2.2. AMSA opposes any restriction in RACGPTP places in the absence of a broad medical workforce reform programme and believes that adequate time for consultation with medical student and doctors-in-training regarding any proposed reforms must be allowed before any changes are implemented. (10/94)
- 8.2.3. AMSA believes that consultation with medical students and Doctors-in-Training must take place regarding RACGPTP entry restrictions. (3/96)
- 8.2.4. AMSA rejects any proposal to further restrict RACGP training positions to areas allocated by the Government or the RACGP. (3/96)
- 8.2.5. AMSA supports the efforts of the AMA Council of Doctors in Training in resolving the dispute between GP registrars and the RACGP over the release of HIC billing data. (3/99)

8.3. Internships

- 8.3.1. AMSA believes all current students at Australian medical schools should be provided with internship placements, and that if overseas students will not be given internship placements that they be told so upon enrolment. (9/95)
- 8.3.2. AMSA believes that States should investigate the most effective and equitable means by which internships may be allocated, whether by academic merit, ballot system or other mechanisms. (9/97)
- 8.3.3. AMSA believes that graduates of Australian medical schools who are Australian citizens or permanent residents, should be given priority in the allocation of internship places over any other applicants. (9/97)
- 8.3.4. AMSA believes each state should give preference to its own graduates in the allocation of internship places. (9/97)
- 8.3.5. While opposing the concept of a "two-year internship", AMSA supports the concept of a subsequent year of generalist medicine, following full registration, before "streaming" into

post-graduate training takes place. This should not preclude access to post-graduate training immediately following the intern year if this is deemed necessary or appropriate. (9/97)

8.3.6. AMSA rejects the concept of examinations in the intern year. (9/97)

8.3.6.1. AMSA believes that National Guidelines should be in place to ensure a minimum standard of internships across Australia. AMSA supports the efforts of the Australian Medical Council and the National Pre-Vocational Training Council to progress the issue of standardised National Guidelines for Intern Training and Assessment. (9/98)

8.3.6.2. AMSA believes that graduates of Australian medical schools who are Australian citizens or permanent residents should be given priority in the allocation of internship places over any other applicants. (9/97)

8.3.6.3. AMSA believes that medical students at Australian medical schools who are Australian citizens or permanent residents should be guaranteed an internship placement. (9/00)

8.3.6.4. AMSA believes that overseas medical students should, as far as possible, be made aware of the likelihood of their obtaining an internship in Australia prior to enrolment. (9/00)

8.3.6.5. In circumstances where the state has inadequate intern places for its own graduates, AMSA believes that the state should give preference to its own graduates in the allocation of internship places. (10/00)

8.3.6.6. AMSA believes that the means by which internships are allocated (whether by academic merit, ballot system or other mechanisms) should be equitable, transparent and efficient. (9/00)

8.3.6.7. AMSA believes that pre-vocational training should be flexible, such that a junior doctor can enter a vocational training programme at any time after completing at least one year in a generalist clinical role. Junior doctors who choose to enter vocational training in later postgraduate years should not be disadvantaged. (9/00)

8.3.6.8. AMSA believes that National Guidelines should be in place to ensure a minimum standard of internships across Australia. AMSA supports the efforts of the Australian Medical Council and the Confederation of Postgraduate Medical Education Councils to progress the issue of standardised National Guidelines for Intern Training and Assessment. (9/00)

8.3.6.9. AMSA believes that all internship placements should carry the option of a community term, in which the intern can gain exposure to general practice or community medicine. (9/00)

8.4. Postgraduate Training

8.4.1. AMSA supports continuing medical education for medical graduates for the purpose of achieving adequate levels of clinical competency. (9/98)

8.4.2. AMSA believes that all Australian medical graduates must have access to postgraduate training which leads to independent practice and the ability to access Medicare rebates for their patients. (9/98)

8.4.3. AMSA believes that the length of postgraduate training should:

- i. Reflect the amount of time required to achieve appropriate levels of clinical competency.
- ii. Not be unduly prolonged. (9/98)

8.4.4. AMSA believes that limitations on access to post-graduate training should not be used to unfairly restrict the medical workforce. (9/98)

8.4.5. AMSA believes that selection processes for entry into post-graduate training programs should be fair, transparent, and open to regular independent review. (9/98)

8.4.6. That AMSA supports in principle the recommended framework for selection of trainees, as stated in the report by Dr Brennan and Company, published in 1997. (7/99)

8.4.7. AMSA demands that the availability of post-graduate training positions be continually monitored to ensure that sufficient career opportunities exist for new graduates. (7/99)

8.4.8. AMSA believes that applicants should have the right to a formal, structured appeals process to review decisions made by a College selection committee, similar to that of the Royal Australasian College of Surgeons. Excessive cost or potential discrimination should not be a barrier to commencing an appeal. (7/99)

8.4.9. AMSA believes that constructive feedback should be given to all applicants who are unsuccessful in gaining selection into a College, in both verbal and written form. (7/99)

8.4.9.1. AMSA supports the compilation of a single document that embodies the policies on selection and appeals of all the Australian training colleges. (7/99)

8.5. Overseas Trained Doctors (OTDs) and Temporary Resident Doctors (TRDs)

8.5.1. AMSA believes that the quota for Overseas Trained Doctors (OTDs) should be adjusted according to the demand in the workforce. (7/90)

- 8.5.2. OTDs must be subject to quality control to ensure that they are of the same standard as locally trained doctors in order that Australia can maintain the same high level of health care which the public now receives. (7/90)
- 8.5.3. AMSA believes that the time spent by overseas students while studying in Australian medical schools and during the intern year should not be counted towards qualification for permanent residency status in Australia. (10/94)
- 8.5.4. AMSA believes that a comprehensive review should be undertaken to establish the number of OTDs entering the Australian Medical Workforce each year. (3/96)
- 8.5.5. AMSA rejects the proposal to reduce medical student numbers until accurate data is obtained on the number of OTDs entering the Australian medical workforce each year. (3/96)
- 8.5.6. AMSA requests that the Department of Health and Aged Care to provide further detail of the 'five year plan' for overseas trained doctors, including exact numbers of OTDs, time course, and possible workforce implications. (7/99)
- 8.5.7. AMSA opposes any reduction in DHAC commitment to rural undergraduate incentives programs as a result of the 'five year plan'. (7/99)
- 8.5.8. AMSA opposes exemptions to the 10-year moratorium for OTDs who choose to work in a rural and remote area. (5/00)
- 8.5.9. AMSA believes that the active recruitment of OTDs should only be implemented as a short-term measure, while attempting to attract significant numbers of Australian graduates to practise in rural and remote areas. (5/00)

8.6. Part-Time Training

- 8.6.1. AMSA supports the availability of part-time training in post-graduate education. (9/97)
- 8.6.2. AMSA believes a doctor's choice of part-time training should have no influence on the selection process of the College. (9/97)
 - 8.6.2.1. AMSA believes that medical practitioners who elect to undertake part-time medical training should not be disadvantaged in their career advancement, and that medical colleges should assist such trainees to complete all training requirements of the particular discipline. (7/99)

8.7. Restriction of the Workforce

- 8.7.1. AMSA believes that consultation with medical students and doctors-in-training must be allowed regarding implementation of workforce reforms before any changes are implemented. (3/96)
- 8.7.2. AMSA rejects any proposal that restricts Medicare rebates to doctors who practice in Government designated areas only. (7/96)
- 8.7.3. AMSA demands that all medical graduates are guaranteed access to a provider number upon registration. (7/96)
- 8.7.4. AMSA calls on the Federal Government to establish adequate workforce data before any further restrictions are placed on the workforce. (3/97)
- 8.7.5. AMSA opposes the capping of Medicare funds available for medical services undertaken by doctors in Australia. (7/99)
- 8.7.6. AMSA does not believe that the 'Approved Medical Deputising Services Program' is consistent with the Minister's undertaking to relax the Provider Number restrictions on junior doctors. (7/99)
- 8.7.7. AMSA calls on the Minister to honour his 1998 commitment to relax Provider Number restrictions in line with the AMA's 'Approved Supervised Medical Services Program' model. (7/99)
- 8.7.8. AMSA believes that a nationwide data system should be developed by AMWAC to monitor the numbers of practising practitioners in the Australian workforce, in total and in different specialties, and according to geographic distribution. (7/99)
 - 8.7.8.1. AMSA believes that ongoing studies should be undertaken by AMWAC to determine the effect of the Provider Number legislation on post-graduate training for junior doctors. (7/99)

8.8. Employment of Medical Students

- 8.8.1. AMSA believes that the employment of medical students by any healthcare provider presents many potential risks to the student, the employer and to patients. For these to be avoided the nature of the agreement should meet the following criteria:
 - i. Medical students should not fulfill, whether employed or not, any role in total or in part, that should only be performed by a registered and qualified medical officer, irrespective of supervision. (3/06)

- ii. AMSA believes any student in the employment of a healthcare provider meets the same qualification standard and receives the same training and education for his/her position as any other member of the public employed in the same position. (3/06)
- iii. Before any conditions of employment are agreed upon, a student should receive a detailed and fully defined job description. Once agreed, the student should never be pressured or expected to take on any extra responsibilities not already defined in the original agreement. (3/06)
- iv. The employee and employer must be aware of the indemnity and legal issues associated with having medical training. (3/06)
- v. Medical students must have adequate indemnity insurance provided by their employer.
- vi. AMSA should endeavour to adequately educate its members of the indemnity and legal issues of employment with a healthcare provider. (3/06)
- vii. A student's decision to enter into a contract of employment with a healthcare provider should not be impacted upon by factors relating to employment opportunities once graduated, or assessment during their medical degree. (3/06)
- viii. The medical training of an employee should not be unnecessarily disclosed to coworkers or supervisors. This serves to promote a working environment where that employee is not exploited for that medical training. (3/06)
- ix. AMSA believes that during designated clinical rotations, a medical student's priority should always be to further his/her education and clinical experience, and that any commitments he/she has, paid or otherwise, should not interfere with this. (3/06)

8.9. Retirement of Doctors

- 8.9.1. AMSA supports the compulsory retirement of doctors from the public hospital system at age 65. (9/93)
- 8.9.2. AMSA does not support the compulsory retirement of doctors from private practice. (9/93)

8.10. Code of Practice

- 8.10.1. AMSA supports the AMA's 'National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors'. (7/99)

8.11. Physician Assistants

- 8.11.1. AMSA is focussed on improving patient outcomes through quality medical education and clinical experience. AMSA believes that Physician Assistants (PA) are an inappropriate

measure to address current workforce shortages in the Australian healthcare system. AMSA believes that their training will undermine and diminish the available resources for medical students and junior doctors. Reducing training opportunities may have a negative impact on the level of clinical experience for Australia's future medical workforce and hence compromise patient safety. For their impact on student teaching, patient safety and the community, AMSA opposes the training and employment of Physician Assistants in Australia in the current climate where clinical training places are insufficient. (06/07)

8.11.2. AMSA believes that (6/07):

- i. the education of PA will reduce the access of medical students and junior doctors to patients and clinicians, to the detriment of their medical education and therefore future patient care.
- ii. the training and employment of PA does not represent a long-term solution to medical workforce shortages.
- iii. there are more appropriate ways to support the Australian healthcare system than PA. For example the resources for the training of PA would be better invested in medical education and greater administrative support.
- iv. the breadth of knowledge required to appropriately diagnose and manage a patient is deeply rooted in medical education and before PA take on such roles their impact on patient safety must be rigorously investigated.
- v. the State and Federal governments, along with universities, need to invest in medical education rather than new models of health-care professional programs in light of increasing medical student numbers.
- vi. AMSA with the AMA should lobby for a moratorium from governments on the employment of Physician Assistants in Australia, until there is clear clinical evidence of effectiveness.

9. Sponsorship

9.1. General

- 9.1.1. As outlined in the Rules and Regulations of the AMSA Official Documents, the Sponsorship Officer is responsible for the coordination of sponsorship, including Convention, for AMSA.
- 9.1.2. Contracts and Memoranda of Understanding (MOU) should not, in general, be longer than 12 months in duration. They may however include the option of review and renewal at the end of the 12 month period. The AMSA Marketing Officers should consider each proposal on its merits and take into consideration specific circumstances when evaluating contract length.
- 9.1.3. The AMSA Sponsorship Guidelines Policy applies to the AMSA, and all AMSA activities including, but not limited to publications, conferences and Conventions.

9.2. Conflict of Interest

- 9.2.1. For the AMSA's purposes conflict of interest is defined as being any interest, financial or otherwise, any activity, or any obligation held by AMSA, its council members or executive, that is incompatible with the stated aims, proper discharge of duties, or has the potential to infringe the AMSA's ability to effectively represent its members or promote their interests.
- 9.2.2. AMSA must maintain the highest ethical and professional standards to avoid conflicts of interest.
- 9.2.3. AMSA commits itself to careful examination of a broad range of information, including the scientific and ethical argument as well as the stated opinion of its membership, in the determination of the existence of a conflict of interest and its remedy.
- 9.2.4. AMSA will not seek nor accept sponsorship from any organisation that is deemed to be a conflict of interest.
- 9.2.5. Determination of the absence of a conflict of interest may be determined by the AMSA council with a 2/3 majority vote.
- 9.2.6. AMSA will not accept any sponsorship from organisations that would prejudice its independence or ability to comply with its aims and policies. Similarly AMSA shall not accept sponsorship that may be deleterious to its members in the execution of their future roles and responsibilities as doctors or indeed their formation.
- 9.2.7. AMSA views the following list of interactions (but is not limited to) as "conflicts of interest":

- i. Receiving any form of sponsorship from Tobacco companies.
- ii. Receiving unreasonable and/or excessive gifts from sponsors, in particular at meetings where negotiations take place regarding potential sponsorship.
- iii. Accepting sponsorship from organisations where a member of council is involved through a relationship such as employment or other that has not been disclosed to the AMSA Council prior to seeking or accepting the sponsorship funds.

9.3. Exclusivity

- 9.3.1. The AMSA will not offer any organisation the option of being the exclusive sponsor of the AMSA.
- 9.3.2. Major sponsors of the AMSA may be given the option of being a patron sponsor of a specific event, at the discretion of the AMSA Executive.

9.4. Advertising

- 9.4.1. The AMSA Executive will have the right to refuse an advertiser or advertisement without justification but with appropriate notice.

9.5. Pharmaceutical Sponsorship

- 9.5.1. The AMSA Sponsorship Policy pertaining to pharmaceutical company sponsorship is as follows:
 - i. To authorise pharmaceutical company sponsorship of AMSA, or an AMSA event, the AMSA council must pass the proposal submitted to it by a two-thirds majority.
 - ii. This policy only requires that, following submission of a proposal for pharmaceutical company sponsorship of AMSA, an AMSA event or an AMSA delegation, its council, make a principle decision to either support or reject the concept of pharmaceutical sponsorship. It does not oblige the council to authorise individual contractual arrangements.
 - iii. The submission must include details of the specific conditions under which pharmaceutical sponsorship will be sought both in terms of whether the budget in question is reasonable and the level to which the budget is in deficit. Consideration should also be given to whether a potential concern pertains to the budget of an AMSA subcommittee or the national AMSA budget.
 - iv. Proposals for pharmaceutical sponsorship of AMSA can only be submitted to council by a chair of an AMSA Committee as recognised by Section 5 of the Regulations and By-Laws of the AMSA Ltd, a head delegate, or a member of the AMSA executive.

Decisions pertaining to this submission shall remain valid for that calendar year only, providing they are pursuant to article 5.1.

- v. The AMSA Executive may request that each council member provide an indication of their medical society's position on pharmaceutical sponsorship prior to the first council meeting of the year, so that its officers might assemble a sponsorship proposal with the reasonable expectation that it be accepted by council.