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Evaluating Paid Positions for Medical Students in Australia: An Online Survey

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Abstract

Objectives: This study evaluates the impact of remunerated medical student (RMS) positions introduced across Australia during the COVID-19 pandemic, focusing on final-year students and recent graduates participating since January 2022.

Methods: An anonymous, cross-sectional online survey using Likert scales (1–5) was distributed across Australian medical schools between March and September 2024. A total of 890 students participated: 141 RMS and 749 non-RMS. Recruitment occurred via social media, emails, and notice boards. The survey explored RMS recruitment, support, job satisfaction, financial compensation, and perceived effects on clinical skills and career preparation. It also examined non-RMS students' views on the program's impact on education and equity.

Results: RMS students reported high job satisfaction (mean = 4.46) and strong preparedness for hospital roles (mean = 4.64). Metropolitan students viewed RMS more positively than rural peers. Nearly half (47.6%) of RMS students reported scheduling conflicts, and 22.6% experienced discrimination, harassment, or bullying. Among non-RMS students, 61.3% reported differential treatment during placements, though 88% supported the program.

Conclusion: RMS roles enhance clinical skills and hospital readiness, with strong support from RMS and non-RMS students. The program should be retained and expanded, improving rural access, scheduling flexibility, and support. Further research should assess long-term outcomes.

I INTRODUCTION

In response to workforce shortages and strain on the Australian healthcare system during the COVID-19 pandemic, hospitals and health departments established remunerated medical student (RMS) positions (Goodall et al., 2024; New South Wales Ministry of Health, 2021a; Queensland Health, 2022). Often called "clinical assistants" or "assistants in medicine", RMS refers to an opt-in paid medical student position within a hospital, typically for final-year medical students (Goodall et al., 2024; New South Wales Ministry of Health, 2021b). In Australia, there are undergraduate and postgraduate entry medical schools that range from four to six years. This is followed by one year of paid internship (Postgraduate Year 1 - PGY1) in a hospital setting before obtaining general medical registration/license (Medical Board of Australia, 2025). Internship includes rotations in core areas and is required for registration with the Medical Board of Australia (Medical Board of Australia, 2025). Various health services offer incentives to students. In the State of New South Wales, RMS are paid 75% of an intern's hourly pay, whereas in the State of Queensland, they are paid 80% of an intern's casual rate (New South Wales Ministry of Health, 2021b; Queensland Health, 2022).

Duties vary from basic medical procedures, such as cannulation and venepuncture, to the initial assessment and management of patients under supervision (Goodall et al., 2024; New South Wales Ministry of Health, 2021a; Queensland Health, 2022). For example, in the general surgery department of a hospital in the State of Victoria, students were responsible for documenting ward round notes, drafting discharge summaries, and scheduling patient follow-up appointments (Goodall et al., 2024). Key limitations of the role include the inability to prescribe or having varying access to patient Electronic Medical Records depending on the health district (Goodall et al., 2024; New South Wales Ministry of Health, 2021a).

Similar positions have emerged globally in response to the COVID-19 pandemic, such as in Ireland and the United Kingdom (Boggon et al., 2023; Callaghan et al., 2023). Overall, medical students expressed a positive outlook for these programs as they believe it enhanced their clinical acumen and gave them a new sense of purpose (Boggon et al., 2023; Callaghan et al., 2023). In New Zealand, students undertake paid pre-internship positions as part of the final-year curriculum, which has been in place since 1972 (Dare et al., 2009).

Recently, Australian-based survey studies, including mixed methods and pilot cohort studies, have delved into the impact of RMS positions on stakeholders such as medical students, supervisors, and the broader healthcare system (Mazzochi et al., 2023; Rupasinghe et al., 2023). Many students found the RMS program helpful in improving their clinical competency and preparing for the following intern year (Goodall et al., 2024; Mazzochi et al., 2023; New South Wales Ministry of Health, 2021a; Rupasinghe et al., 2023). However, because all studies involved medical students from a specific hospital or health district or had a small sample size, findings cannot be generalised to all medical students or services in Australia (Goodall et al., 2024; Mazzochi et al., 2023; Rupasinghe et al., 2023).

To address these limitations, this study provides the first national survey of RMS experiences across multiple institutions and jurisdictions in Australia.

This broader sampling allows for the assessment of supervision, role expectations, remuneration, and perceived educational value that have not been captured in single site studies. It also enables evaluation of equity of student access to RMS positions, consistency of training quality, and the level of institutional support provided to participating students.

Findings from this study carry implications for policy development and workforce planning at both state and federal levels. National data can guide decisions about whether RMS roles should be expanded, standardised, regulated, and incorporated into medical school curricula. They also provide a strong foundation for addressing ongoing financial challenges, notably 'placement poverty', that arise due to placement attendance requirements (Beks et al., 2024).

These results can inform future development of the RMS program post-COVID-19 pandemic and support future health workforce strategies in Australia.

II METHODS

A Study design

A multiple-choice, anonymous online survey was distributed to medical students in Australian medical schools. Advertising graphics and text were shared on Australian Medical Students' Association (AMSA) official Facebook and Instagram pages, emailed to AMSA student members and can be found on the AMSA website. AMSA is the peak representative body of medical students in Australia (Australian Medical Students' Association, 2024). AMSA volunteers posted the survey on individual medical school year-level and cohort social media noticeboards. Six medical school administrators agreed to email the survey to their senior clinical year students (Monash University, University of New South Wales, Australian National University, Western Sydney University, University of Queensland and University of Sydney). Three rounds of advertising were made throughout the survey period with three versions of advertising material. Two AUD \$100 gift cards were advertised to increase response numbers from 3 July 2024.

The public release and trial of the survey began on 11 March 2024 and continued until 13 April 2024. After reviewing the initial responses, minor changes were made to the survey, which was open until 16 September 2024.

B Participant recruitment and selection

While all medical students were able to complete the survey, the focus was on students who had held RMS positions since January 1, 2022, or who have heard of them in their school or health services. The inclusion criteria date was chosen because the COVID-19 pandemic lockdown and restrictions were mostly lifted in all Australian states from the beginning of 2022, which marked the start of routine clinical placements under more typical conditions. The study aimed to capture students' experiences and perspectives of RMS in the post-pandemic setting to inform whether the program should be considered for integration into standard curricula. When the project commenced in mid-2023, selecting January 2022 as the starting point allowed the survey to capture both the perspectives of the 2022 graduates, who had completed the RMS program and were now working as interns, and the experiences of the 2023 students who were undertaking RMS at the time of data collection. This approach ensured that both cohorts contributing to the post-lockdown implementation of RMS were represented.

The ideal sample size was calculated to be 377. This was calculated using Cochran's formula modified with a finite population. The values were set at a 95% confidence level, 5% margin of error, and 50% fraction of the population, with 18,920 medical students enrolled in Australia for 2024 according to the Medical Deans of Australia and New Zealand (MDANZ) database (Medical Deans Australia and New Zealand, 2025).

C Data collection and storage

The primary survey data was collected and stored using Qualtrics XM Platform (Qualtrics, n.d.). The data is stored in a Qualtrics data centre on the West Coast of the USA. After the main survey, participants had the option of entering an email address into a Google form to enter a prize draw. No other identifying information was collected. The Google form is stored in the Google Workspace of AMSA.

D Primary and Secondary objectives

The survey's primary objective was to evaluate whether RMS is a subjectively positive experience for medical students and is worth continuing after the COVID-19 pandemic. Students' opinions of the RMS were assessed using a Likert scale. Questions were asked based on the five aspects of the RMS initiative:

- I. Quality of the recruitment process

- II. Quality of the induction and ongoing support
- III. Job and financial satisfaction
- IV. Impact on their medical education and career
- V. As part of the survey, we also used yes/no questions to assess the variety of tasks performed by RMS student positions.

The secondary objective was to evaluate the effect of RMS on the students who had not taken part in RMS. We asked these students similar questions on the following:

- I. Quality of the recruitment process
- II. Impact on their medical education and career

E Data Analysis and Synthesis

The quality of the survey responses was assessed using Qualtrics features. Duplicates identified using IP addresses and cookies were removed first. The likely responses by computer bots were also removed. Qualtrics uses Google's reCAPTCHA V3 software to generate a likelihood score of whether a bot may have entered each response. Google's standard cut-off value of 0.5 was adopted, where a score less than 0.5 suggests a high likelihood of being generated by a bot. Manual verification was performed to identify suspicious responses based on features such as abnormally rapid completion times, inconsistent IP address locations, and discrepancies in answers. However, these features did not sufficiently differentiate between responses with scores below 0.5 and those of 0.5 or above. To improve dataset reliability, any responses with potential bot activity were excluded.

Responses were measured on a 5-point Likert scale (1 = Strongly Disagree/Negative, 5 = Strongly Agree/Positive), with higher scores indicating greater agreement or positivity depending on the question. For ease of comparison, survey results are grouped and displayed into three categories (Agree, Neutral, Disagree).

Data analysis was performed using IBM SPSS Version 29.0.2.0. To examine whether participant responses varied across subgroups (i.e. gender, location) multivariable binary logistic regression analyses were conducted on each question. For each question, responses were dichotomised into Agree (combining "Somewhat Agree" and "Strongly Agree") and Neutral/Disagree (combining "Neither Agree or Disagree", "Somewhat Disagree" and "Strongly Disagree"). Survey items were analysed for subgroup differences while adjusting for gender, location (metro vs rural), and stage of study (pre-clinical, clinical, graduate). For each categorical variable, the following reference groups were chosen in advance: male gender, metro placement location, pre-clinical stage of study, and domestic student status. Multinomial regression was initially attempted but failed due to sparse responses in some categories. Thus, this dichotomization allowed us to create a clearer analytical framework for examining predictors of agreement. Responses are reported with adjusted odds ratio (aOR) and 95% confidence interval (CI). Statistical significance was defined as $p < .05$. In the Results section, only the statistically significant findings from the binary regression analyses were reported.

A chi-square test of independence was performed to examine the relationship between placement location (Metro vs. Rural) and perception of RMS job promotion.

Responses from a five-point Likert scale were consolidated into a three-point scale to ensure sufficient responses in each group when performing a Chi-square test. This was required to meet the required amount of at least 5 observations in at least 80% of the cells, and to ensure that no cell had less than 1 observation, thus ensuring meaningful statistical analysis.

F Ethics approval

Our investigation was deemed negligible risk research and reviewed and approved via an alternate pathway by the Monash Health Human Research Ethics Committee in the State of Victoria (Reference Number: RES-23-0000-596Q).

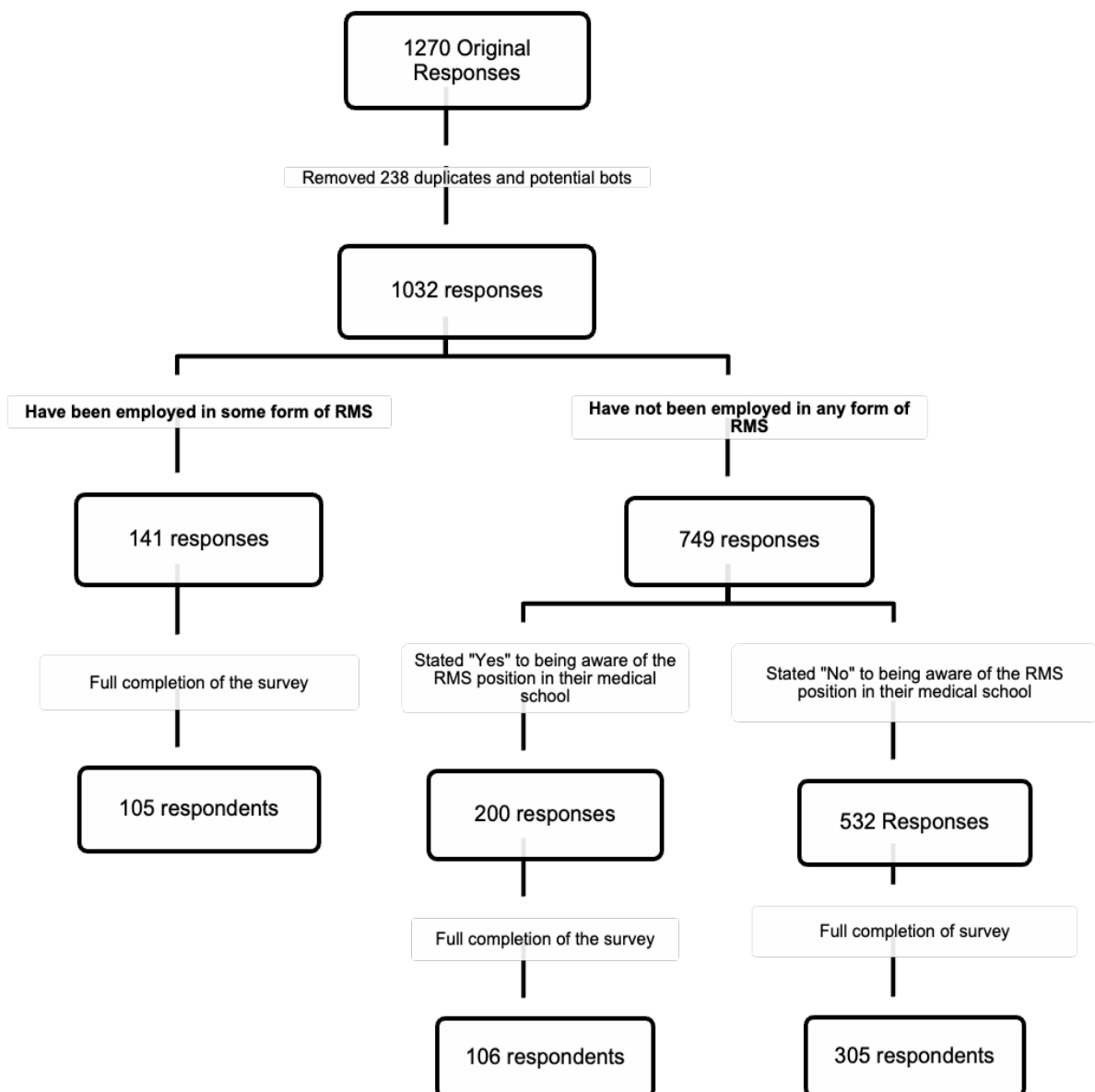
III RESULTS

A Demographics:

The survey received responses from 890 medical students across Australia (Figure 1). The demographic data collected included respondents' gender, year of study, enrolment status, geographic location, and medical school attended.

Figure 1.

Flowchart of Responses



Flowchart depicting the distribution of survey responses on Australian medical students' opinions on Remunerated Medical Student (RMS) positions. A total of 1,270 responses were collected. Duplicate and potential bot responses were subsequently removed, resulting in 1032 viable responses. Respondents were categorised based on whether they had been employed in some form of RMS. Survey responses from students who have been employed were used to collect data for primary objectives. Among those who had not been employed in any form of RMS, 200 students reported that they were aware of the RMS position in their school.

B Primary Objective Results

Table 1

Demographic data of all survey respondents

Demographic Category	All Students (n, %)	Remunerated Medical Students (RMS)* (n, %)	Non-RMS Students** (n, %)
State			
New South Wales	329 (37.0%)	46 (32.6%)	283 (37.8%)
Victoria	147 (16.5%)	29 (20.6%)	118 (15.8%)
Queensland	120 (13.5%)	29 (20.6%)	91 (12.2%)
Western Australia	179 (20.1%)	11 (7.8%)	168 (22.4%)
Tasmania	53 (6.0%)	10 (7.1%)	43 (5.7%)
South Australia	50 (5.6%)	10 (7.1%)	40 (5.3%)
Australian Capital Territory	6 (0.7%)	3 (2.1%)	3 (0.4%)
Northern Territory	6 (0.7%)	3 (2.1%)	3 (0.4%)
Location			
Metro	589 (66.2%)	93 (66.0%)	496 (66.2%)
Rural	301 (33.8%)	48 (34.0%)	253 (33.8%)
Student Type			
Domestic	814 (91.5%)	116 (82.3%)	698 (93.2%)
International	76 (8.5%)	25 (17.7%)	51 (6.8%)
Gender			
Male	376 (42.2%)	76 (53.9%)	300 (40.1%)
Female	496 (55.7%)	62 (44.0%)	434 (58.0%)
Non-binary	7 (0.8%)	0 (0.0%)	7 (0.9%)
Prefer not to say	11 (1.2%)	3 (2.1%)	8 (1.0%)
Stage of Study			
Pre-Clinical	187 (35.8%)	17 (12.1%)	170 (37.1%)
Clinical	290 (55.4%)	69 (48.9%)	221 (55.8%)
Graduate	46 (8.8%)	32 (22.7%)	14 (7.1%)
Total	890 (100%)	141 (100%)	749 (100%)

*Students who responded “Yes” to Q.5, indicating they have been employed in some form of RMS

**Students who responded “No” to Q.5, indicating they have not been employed in any form of RMS

Table 2

Primary objective survey results from Remunerated Medical Students

Factor Evaluated	Mean	SD	Median	IQR	95% CI	Agree/ Positive N (%)	Neutral N (%)	Disagree/ Negative N (%)	N
1. Quality of the RMS recruitment process									
Adequate notification/advertisement	3.76	1.3	4	1	3.50, 4.02	78 (71%)	9 (8.2%)	23 (20.9%)	110
Clear communication of expectations	4.11	1.05	4	1	3.86, 4.55	85 (77.3%)	13 (11.8%)	12 (10.9%)	110
Clarity of application process	4.00	1.23	4	1	3.53, 4.41	81 (73.7%)	11 (10%)	18 (16.3%)	110
Selection fairness (bias-free)	3.92	0.99	4	1	3.02, 3.75	79 (71.8%)	22 (20%)	9 (8.2%)	110
2. Quality of the induction and ongoing support									
Access to necessary tools for role	4.31	0.91	5	1	3.91, 4.50	96 (88.1%)	6 (5.5%)	7 (6.4%)	109
Adequate training provided	4.19	0.99	4	1	3.72, 4.46	91 (83.5%)	9 (8.3%)	9 (8.3%)	109
Flexibility in shift/work allocations	4.15	1.08	4	1	3.35, 4.18	84 (78.5%)	13 (12.1%)	10 (9.3%)	107
Felt burnt out from role	2.62	1.37	2	2	2.58, 3.36	31 (29.2%)	18 (17%)	57 (53.8%)	106
Adequate support pathways available	3.98	1.05	4	1	3.39, 4.02	80 (75.4%)	16 (15.1%)	10 (9.5%)	106
Experienced discrimination, harassment, or bullying	2.35	1.4	2	2	2.42, 3.11	24 (22.6%)	17 (16%)	65 (61.3%)	106
3. Job and financial satisfaction									
Adequate job satisfaction	4.46	0.74	5	1	3.86, 4.43	95 (87.1%)	13 (11.9%)	1 (0.9%)	109
Appropriate compensation/pay	4.33	0.89	5	1	3.92, 4.49	90 (84.1%)	12 (11.2%)	5 (4.6%)	107
Understanding of medical indemnity	3.51	1.38	4	3	3.40, 4.13	66 (61.7%)	10 (9.3%)	31 (29%)	107

Important source of income	4.41	0.8	5	1	3.77, 4.34	90 (84.1%)	15 (14%)	2 (1.9%)	107
4. Impact on their medical education and career									
Impact of RMS on placements (e.g., history taking)	4.43	0.78	5	1	3.66, 4.29	91 (85.8%)	13 (12.3%)	2 (1.9%)	106
Impact on learning & medical education	4.47	0.77	5	1	3.76, 4.41	97 (91.5%)	6 (5.7%)	3 (2.8%)	106
Preparedness for hospital work	4.64	0.61	5	1	4.02, 4.45	101 (95.3%)	4 (3.8%)	1 (0.9%)	106
Advantage in gaining an internship	4.07	1.09	4	1	3.64, 4.30	82 (78.1%)	14 (13.3%)	9 (8.6%)	105

1 *Quality of the RMS recruitment process*

The study assessed the quality of the recruitment process for RMS by evaluating key aspects such as promotion, clarity of job expectations, and the fairness of selection processes. Among Metro-placed participants, 77.0% (n = 57) agreed that RMS jobs are clearly promoted, compared to 58.3% (n = 21) of Rural-placed participants (p=0.003). Conversely, a higher proportion of Rural participants (n = 14, 38.9%) disagreed with the statement than Metro participants (n = 9, 12.2%). Binary logistic regression demonstrated that, after adjusting for gender, stage of study and domestic status, students placed in rural locations for placement had significantly lower odds of agreeing that RMS positions were clearly advertised or distributed (aOR = 0.35, 95% CI 0.13-0.96, p = .041).

Additionally, binary logistic regression analysis conducted on responses to the statement “The RMS selection was without bias” demonstrated that international students were significantly associated with higher odds of agreeing that the RMS position selection process was without bias, when compared to domestic students (aOR = 7.35, 95% CI 1.38-39.08, p = .019).

2 *Quality of the induction and ongoing support*

The study assessed the quality of induction and support for RMS roles by evaluating participants' perceptions of access to tools and resources, adequacy of training provided, quality of support and experiences with workplace discrimination. Binary logistic regression analysis found that female students were more likely than male students to agree with there being flexibility in their work shifts (aOR = 3.43, 95% CI 1.04-11.37, p = .044).

3 *Job and financial satisfaction*

The study assessed participants' perceptions of job satisfaction, compensation, understanding of medical insurance and indemnity, and the financial importance of RMS roles. Results from binary regression analysis demonstrated that females, when compared to male students, had significantly lower odds of agreeing to understanding how medical insurance and medical indemnity works for their role (aOR = 0.41, 95% CI 0.17-0.99, p = .050). Additionally, results through binary regression analysis demonstrated that females, when compared to males, had higher odds of agreeing that their RMS position was an important source of income (aOR = 4.37, 95% CI 1.02-18.77, p = .047).

4 *Impact on their medical education and career*

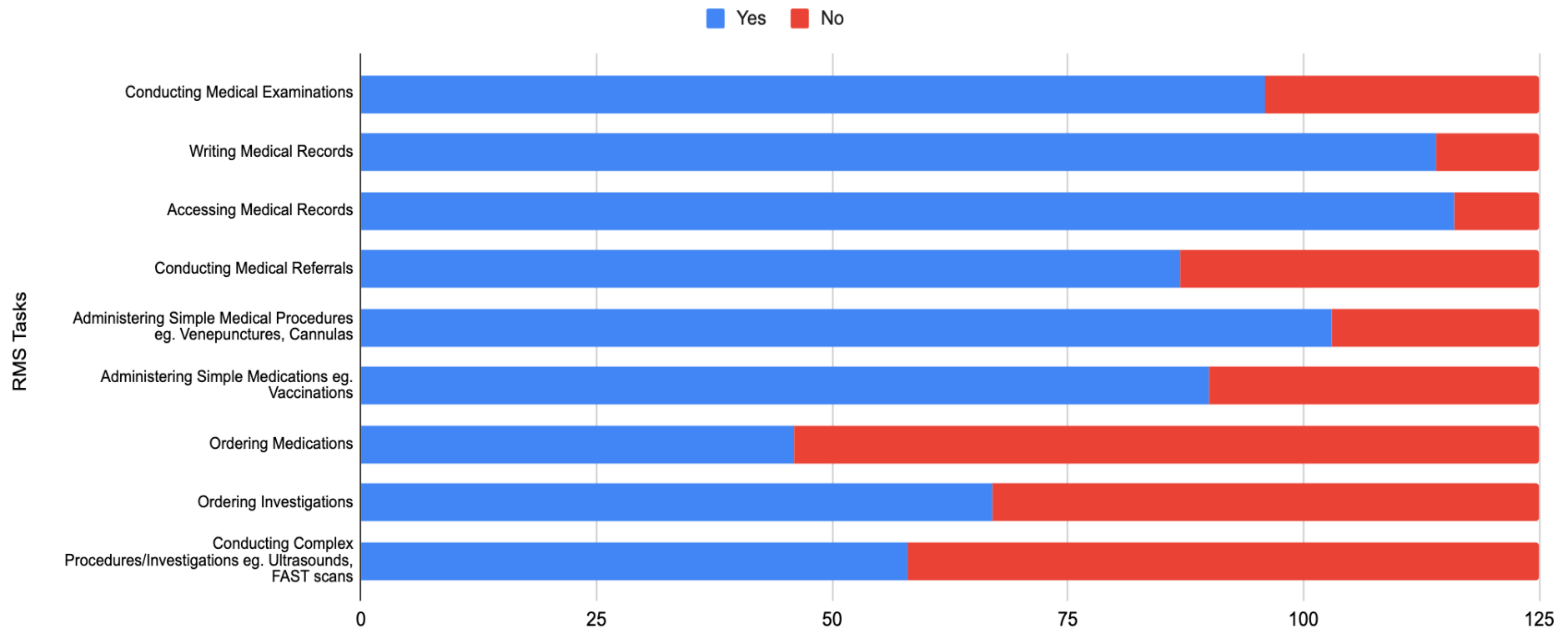
The study assessed participants' perceptions of the RMS program's impact on components of their medical education and career preparation, such as their ability to conduct clinical skills on placements or scheduling conflicts.

Two yes or no questions were also asked; scheduling conflicts with university classes or placements were reported by nearly half of the participants (Q55), with 47.6% (n = 50) in agreement. Participants also reported that RMS reduced their required placement hours (Q56) (44.8%; n = 47).

Students were also asked about tasks performed during their RMS roles, see Figure 2. This figure presents data on the clinical tasks performed by students in remunerated medical student (RMS) positions, based on 125 survey responses. The most performed tasks include conducting medical examinations, writing and accessing medical records. In contrast, fewer students reported tasks such as ordering medications, ordering investigations, and conducting complex procedures such as ultrasounds or Focused Assessment with Sonography for Trauma (FAST) scans.

Figure 2

Remunerated Medical Student (RMS) position tasks conducted by students



Students were posed “Yes” or “No” questions on whether they performed certain clinical tasks throughout their RMS position. There were 125 responses to each question.

Secondary Objective Results:

Table 3.

Secondary objective survey responses from non-Remunerated Medical Student (RMS) position students

Factor Evaluated	Mean	SD	Median	IQR	95% CI	Agree N (%)	Neutral N (%)	Disagree N (%)	N
1. Quality of the RMS recruitment process									
Adequate notification/advertisement	2.46	1.259	2	2	2.18, 2.74	23 (21.7%)	20 (18.9%)	63 (59.4%)	106
Clear criteria for selection	2.52	1.157	2	1	2.27, 2.78	22 (20.8%)	32 (30.2%)	52 (49.1%)	106
Selection without bias	3.05	0.967	3	0	2.84, 3.26	24 (22.6%)	63 (59.4%)	19 (17.9%)	106
2. Impact on their medical education and career									
Impact of RMS on placements (e.g., history taking)	4.05	1.065	5	2	3.81, 4.28	67 (63.2%)	35 (33%)	4 (3.8%)	106
Impact on learning & medical education	4.11	1.1	5	2	3.87, 4.35	72 (67.9%)	30 (28.3%)	4 (3.8%)	106
Impact on application for medical internship	3.99	1.048	4	2	3.76, 4.22	61 (57.6%)	41 (38.7%)	4 (3.8%)	106
RMS program should continue	4.45	1.079	5	1	4.21, 4.69	88 (83%)	12 (11.3%)	6 (5.7%)	106
3. For students who have not done RMS nor have heard of RMS									
RMS should be implemented in your school/hospital	4.69	0.83	5	0	4.21, 4.69	281 (92.1%)	10 (3.3%)	14 (4.6%)	305

Students were asked similar categories of questions as those found in the primary objectives. Non-RMS students who were aware of RMS positions were also asked a yes or no question regarding whether they were treated differently from RMS students on placement, to which a majority (61.3%, n = 65) reported “Yes”.

Binary logistic regression was also conducted on responses from non-RMS students to identify how perceptions of RMS roles differed across subgroups. It was found that when compared to pre-clinical students, clinical students were more likely to support continuation of the RMS program (aOR = 9.90, 95% CI 1.04-94.32, p = .046).

IV DISCUSSION

The national survey demonstrates strong support for the continuation or introduction of RMS positions across Australian medical schools. Overall, most participants perceived their RMS roles positively in terms of job satisfaction, compensation, and financial importance. Many also indicated positive perceptions of the clarity, fairness, and communication of RMS roles. However, areas of concern included burnout and workplace harassment and discrimination.

Perceptions regarding the quality of RMS job promotion differed based on placement location, with metro-placed participants more likely to agree that RMS jobs are clearly promoted compared to rural-placed students. Furthermore, the perception of the quality of the RMS recruitment process was less positive among those who did not participate in RMS but were aware of its existence. Compared to those who have done RMS, a much lower proportion of respondents who have not done RMS believe there were adequate advertisements in their school (21.7% compared to 70.9%).

A notable portion of the respondents who did RMS (n = 31, 29%) felt they did not have a good understanding of how medical insurance and indemnity worked for their role. This lack of understanding was more frequently reported by female students. These findings highlight the need for better education surrounding medico-legal responsibilities and indemnity coverage, particularly since RMS is still in its infancy and implementation is variable across states.

This survey revealed that the scope and role of the RMS programs are largely the same as previously reported studies in Australian states such as New South Wales and Victoria (Mazzochi et al., 2023; New South Wales Ministry of Health, 2021a; Rupasinghe et al., 2023). Most students undertook documentation and simple procedures such as cannulations, with fewer respondents conducting more advanced tasks such as ordering investigations. The scope and role also align with RMS equivalent roles in the UK and Ireland (Boggon et al., 2023; Callaghan et al., 2023; Freimane et al., 2021). Unexpectedly, 46 respondents (36.8%) reported ordering medication as part of their RMS duties. Of these 46 respondents, 18 (39.1%) are from New South Wales. New South Wales Health has previously reported this task as a limitation to the RMS program as students lack a prescriber number (Mazzochi et al., 2023). Thus, it is likely that RMS students ordered medications under clinician supervision. Overall, the survey results suggest that the current model of RMS requires students to possess a broad range of skills from gathering history, making referrals and conducting simple procedures, rather than fulfilling a specific need such as triage assistant (Davis et al., 2011) or COVID swab personnel (Klasen et al., 2020). The data aligns with AMSA's call in 2023 for RMS positions to act as an adjunct to the roles of junior doctors rather than a replacement (Australian Medical Students' Association, 2023b).

RMS positions continue to provide a positive experience for students beyond the COVID-19 pandemic era. This survey reinforces the positive reports of single-site RMS studies such as those in Eastern Health and Western Health in Victoria (Goodall et al., 2024; Mazzochi et al., 2023). However, the abundant clashes of RMS duties with students' university education commitment reported in the survey (n = 50, 47.6%) continues to be an issue, as identified by New South Wales Health in 2021 (New South Wales Ministry of Health, 2021a).

While RMS positions may be viewed as comparable to a part-time job that students have to learn to balance with medical school, RMS positions share a lot of similarity with the pre-intern

year model for New Zealand medical students due to its clinical nature and educational alignment. The New Zealand curriculum has had a pre-intern year as their final year of medical school since 1972, where students are paid a stipend during this transition year (Dare et al., 2009). The medical schools are the main stakeholders for the pre-intern year, thus allowing educational priorities to remain central (Dare et al., 2009).

Most respondents (55.2%) said RMS has not reduced the number of hours required in clinical placements. Australian medical programs are time intensive. For example, Flinders Medical School expects a minimum of 37.5 hours per week and up to 50 hours per week for clinical year students for work integrated learning (Flinders University, 2024), and the Sydney Medical School requires 2310 hours of work placement for their students across the degree (Colenbrander et al., 2020a). This limits the capacity for students to undertake paid work and support themselves outside their university commitments. Furthermore, Australia is currently experiencing a “cost of living crisis” where people are increasingly struggling with the gap between real wages and the increase in the cost of goods and services (Heap, 2024). A majority (84.1%) of respondents who did RMS believed the position to be an important source of income. The same proportion of students also believes RMS positions provide appropriate pay. Considering the above, RMS may serve as a meaningful form of financial support for medical students if rolled out more broadly across the country. This may be particularly evident for female students, as they were over 4 times more likely to agree that RMS was an important source of income for them compared to male students.

One concerning finding was the presence of harassment and discrimination surrounding RMS positions. Nearly a quarter of RMS students (22.6%) reported that they experienced discrimination, harassment or bullying during the role. This is almost identical to the data reported in Australia’s 2023 Medical Training Survey, where 22% of doctors in training reported experiencing bullying, harassment, discrimination and/or racism (Medical Board of Australia and Australian Health Practitioner Regulation Agency, 2023). Unfortunately, this is the same percentage found in the 2022 Medical Training Survey. This finding suggests a more systemic issue in the healthcare setting; however, it is possible that sources of discrimination for doctors are different to medical students. Since 2015, AMSA have had an official policy on bullying and harassment in medicine. The latest iteration, released in 2023, recognises that bullying and harassment is a major problem that prevails within medical education, which has a major effect on student wellbeing. The policy calls upon regulatory bodies and medical schools to improve their policies and processes, such as implementing disciplinary actions against healthcare professionals who engage in bullying and harassment (Australian Medical Students’ Association, 2023a).

While our survey did not investigate the source of harassment and discrimination, medical students may have experienced it from patients and other healthcare workers (Colenbrander et al., 2020b). Furthermore, 38.7% of non-RMS students felt they were treated differently from RMS students on clinical placements. This is significant as RMS jobs are not compulsory in the medical school curriculum and have limited spots available. Given existing evidence of the prevalence of discrimination faced by medical students on the basis of race, religion, sex, ethnicity, and sexual orientation (Ng et al., 2020), medical schools should ensure RMS does not become a new source of discrimination. Differential treatment and negative experiences on clinical placement strongly impact how students choose their future specialties (Kaur et al., 2025). Furthermore, negative social interactions and discrimination in higher education or clinical environments have been shown to be associated with lower academic achievements (Schneider & Preckel, 2017; Zaccariah et al., 2025), emphasising the importance of safe and equitable educational environments.

V RECOMMENDATIONS:

Our study has demonstrated that RMS can be a positive addition to the medical school curriculum, and there are several recommendations for the ways it can be implemented. To ensure quality and consistency, it would be fair and beneficial to Australian medical students

across all States and Territories to develop a national RMS framework. RMS should also be included in the Standards for Assessment and Accreditation of Primary Programs, which lists the overarching expectations of all Australian and New Zealand medical schools (Australian Medical Council, 2023). Selection criteria and the amount of payment may draw on existing frameworks such as the 2025 Commonwealth Prac Payment program, which provides support to eligible students studying bachelor's or master's degrees in teaching, nursing, midwifery or social work (Australian Government Department of Education, 2025).

Like New Zealand, any pre-intern program, such as the RMS should be primarily managed by medical schools as an extension of students' education rather than standalone employment within health services. This approach allows for easier allocation of students' schedules and avoids conflict between schooling and RMS commitments. Medical schools should circulate guidance to hospital healthcare professionals regarding the scope and expectation of RMS students and reaffirm that participation in RMS positions should not influence the treatment of students. Lastly, clear reporting and accessible escalation pathways for bullying and harassment, that are independent of clinical hierarchies, should always be available to students.

VI LIMITATIONS

The voluntary nature of the survey and its distribution through social media channels may have introduced selection bias. This approach may have led to an uneven representation across medical programs, with some universities contributing few responses. Hence, there might be sites where RMS programs exist but are not represented in our dataset. The nature of the online survey, mainly promoted through social media platforms Facebook and Instagram, presents the risk of having non-current or past medical students complete the survey. However, this risk is believed to be low as the survey was advertised to locations that are likely to contain only medical students or graduates, such as clinical school-specific social media groups. Future studies can reduce the risk of selection bias by using coordinated distribution through institutional email lists and applying proportional quotas or stratified sampling across universities.

The broad inclusion period, dating back to January 2022, increases the likelihood of recall bias. This timeframe was considered necessary to capture both the 2022 and 2023 final year cohorts. However, it remains a source of potential inaccuracy. Despite these limitations, our study exceeded the ideal sample size of 377; it provides a valuable preliminary evaluation of post-pandemic era RMS across multiple states. Future directions for research should include assessing the impact of the RMS program on the healthcare system and its efficiency across multiple states, adding to the results of a small pilot study in New South Wales in 2023 (Rupasinghe et al., 2023).

VII CONCLUSION

RMS positions are beneficial learning opportunities for students even after the COVID-19 pandemic. It provides a valuable source of income for medical students during Australia's "cost of living crisis", and most students believe that it should either be continued or be introduced to their clinical school. However, several possible improvements have been identified. The promotion and recruitment process of RMS positions should be made more transparent. Integrating RMS into the medical school curriculum, like New Zealand's pre-intern year model, may be beneficial. Lastly, health services and medical schools should ensure students are better protected from harassment and discrimination on the job or on placements. Furthermore, medical schools need to facilitate an environment in which not participating in RMS does not become a factor of discrimination among students.

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References

- Australian Government Department of Education. (2025). *Commonwealth Prac Payment (CPP) - Department of Education, Australian Government*. Department of Education. <https://www.education.gov.au/commonwealth-prac-payment-cpp>
- Australian Medical Council. (2023). *Standards for Assessment and Accreditation of Primary Medical Programs* (pp. 1–33). https://www.amc.org.au/wp-content/uploads/2023/08/AMC-Medical_School_Standards-FINAL.pdf
- Australian Medical Students' Association. (2023a). *Policy Document: Bullying and Harassment in Medicine* (2023). Australian Medical Students' Association. <https://amsa.org.au/wp-content/uploads/2023/10/Bullying-and-Harassment-in-Medicine-2023.pdf>
- Australian Medical Students' Association. (2023b). *Policy Document: Clinical Placements and Remunerated Medical Student Positions*. <https://amsa.org.au/wp-content/uploads/2023/10/Clinical-Placements-and-Remunerated-Medical-Student-Positions-2023.pdf>
- Australian Medical Students' Association. (2024). *About AMSA*. <https://amsa.org.au/about/>
- Beks, H., Walsh, S., Clayden, S., Watson, L., Zwar, J., & Alston, L. (2024). *Financial implications of unpaid clinical placements for allied health, dentistry, medical, and nursing students in Australia: A scoping review with recommendations for policy, research, and practice*. BMC Health Services Research, 24(1), 1407. <https://doi.org/10.1186/s12913-024-11888-y>
- Boggon, A., Poole, A., Smith, S., Burns, A., & Dilworth, P. (2023). *Medical students as health workers during the COVID-19 pandemic*. BMJ Leader, 7(2), 149–151. <https://doi.org/10.1136/leader-2022-000597>
- Callaghan, J. P., Freimane, K. Z., Kearney, G. P., & Hart, N. D. (2023). *(L)earning: Exploring the value of paid roles for medical students*. Clinical Teacher, 20(2), 1–9. <https://doi.org/10.1111/tct.13563>
- Colenbrander, L., Causer, L., & Haire, B. (2020a). *'If you can't make it, you're not tough enough to do medicine': A qualitative study of Sydney-based medical students' experiences of bullying and harassment in clinical settings*. BMC Medical Education, 20(1), 1–12. <https://doi.org/10.1186/s12909-020-02001-y>
- Colenbrander, L., Causer, L., & Haire, B. (2020b). *'If you can't make it, you're not tough enough to do medicine': A qualitative study of Sydney-based medical students' experiences of bullying and harassment in clinical settings*. BMC Medical Education, 20(1), 1–12. <https://doi.org/10.1186/s12909-020-02001-y>
- Dare, A., Fancourt, N., Robinson, E., Wilkinson, T., & Bagg, W. (2009). *Training the intern: The value of a pre-intern year in preparing students for practice*. Medical Teacher, 31(8). <https://doi.org/10.1080/01421590903127669>
- Davis, D. J., Moon, M., Kennedy, S., DelBasso, S., Forman, H. P., & Bokhari, S. A. J. (2011). *Introducing Medical Students to Radiology as Paid Emergency Department Triage Assistants*. Journal of the American College of Radiology, 8(10), 710–715. <https://doi.org/10.1016/j.jacr.2011.06.002>
- Flinders University. (2024). *Medicine placement requirements*. Flinders University. <https://students.flinders.edu.au/my-course/placements/compliance/medicine>
- Freimane, K. Z., Callaghan, J. P., Kearney, G. P., & Hart, N. D. (2021). *So you want to be a: Medical student technician?* Ulster Medical Journal, 90(3), 194–196.

- Goodall, R., Matejin, E., Fabri, S., & Eleftheriou, P. (2024). *Medical students: A potentially sustainable solution for our workforce crisis and future reforms in health care*. Medical Journal of Australia, 220(4), 176–179. <https://doi.org/10.5694/mja2.52200>
- Heap, L. (2024). *Doing it Tough: How Australians are experiencing the cost of living crisis* (pp. 1–41). The Centre for Future Work at the Australia Institute.
- Kaur, G., Peng, K., Urwin, R., Westbrook, J. I., & McMullan, R. D. (2025). *Is There a Relationship Between Medical Student Mistreatment and Specialty Choice and Career Intentions? A Systematic Review*. Medical Science Educator, 35(3), 1777–1786. <https://doi.org/10.1007/s40670-025-02340-9>
- Klasen, J. M., Meienberg, A., Nickel, C., & Bingisser, R. (2020). *SWAB team instead of SWAT team: Medical students as a frontline force during the COVID-19 pandemic*. Medical Education, 54(9), 860. <https://doi.org/10.1111/medu.14224>
- Mazzochi, K., Aldridge, E., Hackett, L., Miller, J., Leach, D., Lukins, J., Jordan, P., & Buntine, P. (2023). *Medical student deployment to a single metropolitan hospital during the COVID-19 pandemic: A mixed methods analysis*. EMA - Emergency Medicine Australasia, 35(6), 960–967. <https://doi.org/10.1111/1742-6723.14273>
- Medical Board of Australia. (2025). *Medical Board of Australia—Interns*. <https://www.medicalboard.gov.au/Registration/Interns.aspx>
- Medical Board of Australia and Australian Health Practitioner Regulation Agency. (2022). *Medical Training Survey 2022* (pp. 1–191). <https://www.medicaltrainingsurvey.gov.au>
- Medical Board of Australia and Australian Health Practitioner Regulation Agency. (2023). *Medical Training Survey 2023* (pp. 1–116). <https://www.medicaltrainingsurvey.gov.au>
- Medical Deans Australia and New Zealand. (2024). *2019-2023 Data from Final Year Students at Australian Medical Schools*. Medical Schools Outcomes Database National Data Report 2024 Background. <https://medicaldeans.org.au/md/2024/05/MSOD-National-Data-Report-2024.pdf>
- New South Wales Ministry of Health. (2021a). *Assistant in Medicine: Evaluation Report*. New South Wales Health. <https://www.health.nsw.gov.au/workforce/medical/Publications/aim-evaluation-report.pdf>
- New South Wales Ministry of Health. (2021b). *Assistant in medicine: Frequently asked questions*. New South Wales Health. <https://www.health.nsw.gov.au/workforce/medical/Factsheets/aim-faqs.pdf>
- Ng, L., Lin, C., & Henning, M. A. (2020). *A Narrative Review of Discrimination Experienced by Medical Students*. Medical Science Educator, 30(1), 577–584. <https://doi.org/10.1007/s40670-019-00878-z>
- Qualtrics. (n.d.). Qualtrics XM (Version October 2024) [Computer software]. <https://www.qualtrics.com>
- Queensland Health. (2022). *Health Employment Directive*. Queensland Government. https://www.health.qld.gov.au/__data/assets/pdf_file/0036/1184868/HED-05.22-Employment-framework-Students-in-Medicine.pdf
- Rupasinghe, S., Majeed Omar, M., & Berling, I. (2023). *Final year medical students as Assistants in Medicine in the emergency department: A pilot study*. EMA - Emergency Medicine Australasia, 35(4), 600–604. <https://doi.org/10.1111/1742-6723.14173>
- Schneider, M., & Preckel, F. (2017). *Variables associated with achievement in higher education: A systematic review of meta-analyses*. Psychological Bulletin, 143(6), 565–600. <https://doi.org/10.1037/bul0000098>

Zaccariah, Z. R., Lefroy, J., & Wenning, B. (2025). *'Never Going to be a Cut Above [the Rest].'* *Medical Students' Perceptions of How Their Personal Protected Characteristics Impacted Surgical Learning*. *Medical Science Educator*, 35(4), 2075–2088.
<https://doi.org/10.1007/s40670-025-02415-7>