# The Current Status of Risk Assessing Undergraduate Medical Electives: A UK Consensus to Inform Recommendation for Future Practice


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**For the Medical Schools Council (MSC) Electives Committee**

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**Abbreviations**
GMC – General Medical Council
MSC – Medical Schools Council
NHS – National Health Service
RA – Risk Assessment
UK – United Kingdom

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**What this paper adds**: This is a UK medical schools consensus paper which provides a summary of who does, and checks, risk assessments for international elective placements. If offers, on behalf of the Medical Schools Council UK Electives Committee, recommendations for templating risk assessments to keep students, host organisations, patients and the public safe.


## Abstract

**Background:** Electives are well established in healthcare education, particularly medicine. They usually involve extended placements in the home country or across the world. The benefits are well-documented in terms of student maturation, exposure to new settings, professional development, clinical skills and so forth. The majority take place outside of the home institution. Supporting students to develop comprehensive risk assessments is crucial for their safety, and that of patients and public.

The Medical Schools Council (MSC) Elective Committee, comprising elective leads from all UK medical schools, collaborate on improving electives practices and pooling expertise. As risk assessment has been a topic of debate (exacerbated by Covid) it was decided to survey members regarding their risk assessment practices, with the aim of generating a set of recommendations that UK medical school, and others, can employ as a benchmark when developing risk assessments and updating safety processes.

**Method:** Elective leads from 26 of 32 UK Medical Schools, shared their approaches to electives risk assessment via a mix-method questionnaire. An elected subgroup of the MSC Electives Committee collated responses in order to generate a comprehensive set of electives risk and safely recommendations. Free text additions were considered thematically.

**Results:** The study found variation in risk assessment approaches and inclusions as well as variation in where responsibility lies for risk assessing. Results enabled us to generate a template that can be applied flexibly and according to the individual requirements of any healthcare programme that includes an elective placement. Risk assessment items such as “local custom”, “laws”, “location safety”, “ethics and discrimination” are examples of additions which were added to the more traditional risk assessment considerations such as “travel insurance”, “communicable diseases” and “Personal Protective Equipment”.

**Conclusions:** It is recognised that differences in location, learning objectives, length and type of elective placement, prevents a more formalised and rigid risk assessment recommendation. However, for any medical school or other organisation undertaking risk assessment of an elective, a flexible template of recommendations is offered by this consensus paper. Replication of the study to capture post-pandemic additions would be a worthwhile exercise.

**Introduction:** For this paper the term 'elective' represents an extended healthcare experience organised by the students, while aligned to the requirements of their respective programmes. Electives are components of undergraduate medical curricula worldwide and have been widely discussed (Edwards *et al.,* 2004; Dowell and Merrylees 2009; Ackerman 2010; Cherniak *et al.,* 2013). Moreover, electives feature in a range of healthcare disciplines (Peate 2008; Martinez Mier *et al.,* 2011) and have a significant historical context. The importance of global health in undergraduate training is recognised (Battat *et al.,* 2010) and elective programmes can offer this as an option (Hastings *et al.,* 2013). The Edinburgh Declaration (World Federation for Medical Education, 1988, no page) emphasised the prerogative to "1. enlarge the range of settings in which educational programmes are conducted to include all health resources in the community, not just hospitals alone".

Consequently, electives are an important example of how medical and other healthcare programmes can educate —and professionalise — students, by exposure to a variety of out-of-hospitals settings including, for example, community-based charities and organisations (e.g. hospice care, social prescribing (Thompson and Murdoch-Eaton, 2017) and mountain rescue (Larsen *et al.,* 2019). They offer a period of novel experience, characterised by experiential learning and reflective practice, consolidating prior learning and accelerating professional and ethical development through personal experience of the global and social determinants of health. Moreover, electives offer a useful means for students to observe the productivity and professionalism of a diverse medical workforce seen on an elective placement, including role models in resource limited (or abundant) settings. In due course, students look to apply this unique experience in the NHS when they start Foundation (UK Junior Doctor) posts.

While elective modules vary between medical schools, they typically involve a level of student engagement and choice pertaining to context, location and content. This is formally recognised by the UK General Medical Council (GMC) as part of the required Student-Selected Component of a medical curriculum, with learning outcomes mapping to 'Outcomes for Graduates' (General Medical Council, 2018). From past literature, in around 80% of cases students selected an international setting (Miranda *et al.,* 2005; Murdoch-Eaton *et al.,* 2011), although of course this is subject to local variation. In more recent years home-based placements, i.e. the student's country of regular study, increasingly gained ground for reasons of practicality (e.g. cost; personal commitments), content (e.g. service speciality; research expertise) or objective (e.g. substantive career taster). This trend was further impacted by the SARS-CoV2 pandemic of 2020, which necessitated a cessation of international elective placements (Egiz and Storz, 2021 and Storz, 2022).

While international electives have resumed in many countries, in the post-pandemic UK environment of 2023, anecdotal narratives from students and members of the Medical Schools Council (MSC) Electives Committee suggests that within the UK, the increase in requests for home-based electives has continued. Whilst reasons for this increase is presently unclear, two possible drivers may include: i) the financial pressures related to the rapid increased cost of living faced by the wider population, including medical students, ii) post-pandemic increase in social anxiety disorder (Kindred and Bates, 2023), since both may potentially influence a given student's choice of elective location. Of those choosing to leave their country of study, many gravitate towards low and middle-income settings (Miranda *et al.,* 2005; Murdoch-Eaton *et al.,* 2011) to experience a contrasting clinical or educational context. Increasing costs of education, and electives, will influence participation by students from poorer communities, restricting choice and experience (Gulland, 2018).

Elective programmes in the UK date back to the 1970s (anonymous, 1993) and offer a well-recognised and documented rationale for being both useful and engaging (Cruikshank and Walsh, 1980; Huntington *et al.,* 2003; Racine & Perron, 2012; Lumb & Murdoch-Eaton, 2014). Electives have links to appreciation of social determinants of health, understanding of global public health agendas and fostering positive attitudes towards working with different populations where resources may be restricted (Jeffrey *et al.,* 2011). Established benefits include exposure to illness narratives, conditions and diseases not prevalent in the student's own study location, the opportunity to develop organisational and coping skills, and the chance to develop cultural competency. They can equip participants with new skills, and/or consolidate prior learning (Cruikshank and Walsh, 1980; Thompson *et al.,* 2003).

In terms of formal risk assessment (RA), advice given to previous generations of UK students travelling overseas was inconsistent and focused primarily on recognition and prevention of infectious diseases (Moss *et al.,* 1999; Cossar *et al.,* 2000; Tilzey *et al.,* 2002; Vlot *et al.,* 2020). Subsequently came wider recognition of the need to conduct more formalised RAs for eventualities including trauma, crime and fatality (Tyagi *et al.,* 2006). Over the past decade concerns have been expressed about potential liability of students for untoward events while working overseas. Host institutions and other elective providers have varying approaches to provision of logistic and professional cover for students. Most clinical placements that medical students experience as part of their registered programmes of undergraduate study are designed, overseen and quality assured by their own medical schools (and regulatory bodies), where there are established guidelines, reporting paths, support systems, and processes available to students should they experience an unpredicted challenge or situation on

placement. On elective, however, this may not be the case; the student could be exposed to an entirely new context of risk and risk management. This consideration is not exclusive to international electives, but clearly the environment, climate, and culture of distant locations exacerbates the need for advanced planning and diligence. One might argue that the strength of elective programmes lies in the sheer breadth and diversity of highly individualised experiences on offer, but by the same token this strength creates a challenge for those responsible for them. On the one hand it is important to encourage learners to develop resilience and problem-solving ability commensurate with first day of work as a junior doctor, on the other hand, such opportunities inevitably expose participants to elevated levels of risk, bias, unfamiliarity and uncertainty. How then might schools best prepare their students, and keep them safe, without compromising their spirit of choice, self-development and maturation that lies at the heart of the elective experience? This question was a focus of attention for the MSC Electives Committee. The committee comprises the Elective Module Leads of each participating UK medical school. The group meet bi-annually to exchange ideas, share best practice, influence programme development at national level and collaborate on educational and research initiatives. At the time of writing, 35 schools were registered with 32 having voting members eligible to participate in this evaluation. The committee previously produced a consensus set of recommendations for elective planning, elective content and post elective consolidation (Wiskin *et al.,* 2018). The emphasis on risk management emergent from that consultation drove the present initiative – creation of a set of detailed recommendations for preparing students for unfamiliar situations ahead of departure.

The aim of this study was to generate a document that benchmarks and progresses elective RA practices in the UK, as an addition to recommendations from other countries (Johnston *et al.,* 2018; Watson *et al.,* 2019). International medical electives are a well-established part of curricula beyond the UK, although mainly in higher income settings, e.g., Australia and Canada (Miranda *et al.,* 2005; Izadnegahdar *et al.,* 2008; Law *et al.,* 2013). It is the MSC Electives Committee's hope, therefore, that this work will be relevant to many locations and include all healthcare professions which have elective activity in their curricula.

**Methods:** The MSC Electives Committee elected a subgroup initially comprising four medical schools to scope a proposal. The proposal – based on minutes of previous MSC Electives Committee discussions and a literature review – was first presented and approved at the MSC Electives Committee in 2019. A second iteration of evaluation questions (refined by wider discussion at that meeting and signed off by the committee Chair and MSC Elective Lead) was developed and circulated to the nominated lead for each UK medical school in 2020. Circulation was via a well-established

JiscMail (national academic mailing list service) account already used by MSC Elective Committee membership for elective discussions. Each lead received a link to the investigator's Microsoft Forms survey account, the tool used to collect, collate and analyse responses. Prior to distribution of the final survey all members were sent the question list for additions or amendments. The survey link was live for three weeks. Preliminary results were drafted by a risk assessment subgroup into a discussion paper presented to members at the Annual General Meeting.

**Ethical Considerations:** Approval was granted by the University of Birmingham Research Ethics Panel (Ref ERN19-0951). As all participants were members of the national group who internally commissioned the survey, ethical risk was low. The aims and expectations of the project, along with a confidentiality confirmation, were placed at the top of the survey. Consent was implied by submission of the survey.

As this was a collaborative project (to achieve a consensus) rather than a research endeavour there was no 'participant recruitment'. Only stakeholders who had pre-agreed the initiative were included. Confidentiality was maintained as the MS Form did not store identifiers for any individual or institution. The MSC Electives Committee subgroup explained to stakeholders that any relevant internal conversations about permissions (e.g. Elective Colleagues, Year Lead, Programme Head) should be had before taking part. For data management, University of Birmingham data protection and storage guidelines were applied.

We are reporting process, rather than experience or application of process, so the study looked primarily at similarities and differences between schools' risk assessment forms. There were no sensitive data. The aim was simply to establish current practice in each responding school in order to present a set of collective recommendations that schools could consider, or not, depending on the (unique) nature and need of their course.

**Questionnaire Design:** The design process involved:

- Initial discussion at the MSC Electives Committee Annual General Meeting to establish the aims of the project. This was concluded as establishing current practice in each responding school in order to present a set of proposed inclusions.
- The MSC Electives Committee subgroup drafted the initial rationale and questions for subsequent whole group circulation and feedback.
- A refined iteration of the questionnaire was (dummy) piloted within the subgroup for usability.
- Final questionnaire was agreed by MSC Electives Committee

**Results:** Twenty-six schools (81% of *n*=32) of those represented at the MSC Electives Committee returned the questionnaire. Two responses were returned by support staff, the rest by academic leads.
Quantitative responses are presented in tables and text. Themes from free text comments were classified by one investigator (JR) and blind verified by a second (CW).
Findings and outcomes are presented as:

- A – operational & logistic factors, for context.
- B – risk assessment content informed the blueprint for this set of national recommendations
- C – free text comments.

### *A. Operational factors and logistics*

#### 1. Who does the risk assessment (RA)?

This refers to the *physical completion* of the form/template. For the majority (*n*=13 (50%)) the responsibility for RA completion was with the student. Seven schools reported supervisor and student involvement. In three cases the elective lead undertook the RAs for their cohort (Table 1).

| Who undertakes the RA? | *n* Medical Schools |
|---|---|
| The student | **13** |
| Supervisor and student separately | **4** |
| Supervisor and student together | **3** |
| The elective programme lead | **3** |
| Support staff | **2** |
| Risk assessment not applicable | **1** |

**Table 1: Risk Assessor**

#### 2. Who checks the risk assessment process has been completed?

This refers to responsibility for checking the RA has been done. Results are shown in Table 2, with the majority (*n*=17 (74%)) citing the Elective Lead as responsible.

| Who checks the RA? | *n* Medical Schools |
|---|---|
| Elective Lead | **17** |
| Student | **4** |
| Someone else (usually a coordinator/administrator) | **5** |

**Table 2: Person responsible for checking the RA is completed**

#### 3. Do elective hosts contribute to advance risk assessments?

A small number (*n*=4 (15%)) routinely ask for information from the host to inform their overall health and safety preparation. Of the remaining 22(85%), the majority (*n*=18 (69%)) said “no” (Table 3).

| Do you ask elective hosts to provide advance risk assessments for health & safety information? | *n* Medical Schools |
|---|---|
| No | **18** |
| Yes | **4** |
| Sometimes | **4** |

**Table 3: Elective Host Provision of RAs**

### 4. Do you risk assess research?

Over half of responding schools (*n*=16 (62%)) do risk assess research (Table 4). This question was broad because student research encompasses all manner of projects (lab-based, desk-based or subject-facing interviews etc.). Whilst each of these types of research should be risk-assessed (to include ethical review) it is important that the relevant Elective Lead is aware of this.

| **Do you risk assess research?** | ***n* Medical Schools** |
|---|---|
| Yes | **16** |
| No | **7** |
| Sometimes | **3** |

**Table 4 – RAs for research**

### 5. Which information sources are students directed to?

The majority, 16 (66%) directed learners to elective information online, as reported in Table 5.

| **Where do you direct students for risk related information?** | ***n* Medical Schools** |
|---|---|
| Online resources | **16** |
| A (provided) elective pack | **5** |
| **Other*** | **5** |

**Table 5: Risk-related information**

***Other** includes Occupational Health and General Practitioner, where there is not an overall pack advising this.

### 6. 'Closing the loop'

The final question asked if the relationship between perceived risk (pre-departure) and actual risk as experienced during the elective) is checked on return. Six schools (23%) do explicitly check this, 6 (23%) sometimes check this, however, the majority *(n=14 (54%)* do not.

## *B. Risk assessment Content*

Respondents were asked to indicate if their current RA included the items detailed in Table 6. There was an option to add items*.

***Added Items included:**

- Curtailment and additional high risk activity insurance
- Isolation and homesickness
- Language barriers – and resource implication to host
- Religion (both tolerance, and access to worship abroad)
- Knowing the political construct, culture and context
- Legal requirements
- Social media
- HIV (and other infectious disease) prevalence
- **Pandemics***

***Pandemics** emerged as an obvious priority during write up. The questionnaire was circulated just before the Covid-19 global disruption. Respondents, therefore, initially completed their recommendations for our RA study based on the 'pre-coronavirus' climate they were operating in at the time. The pandemic delayed write up, as committee members were diverted to other priorities. This is picked up in the discussion.

| Do your RAs ask for the following information? | *n* Yes answers |
|---|---|
| Contact details | **25** |
| Destination address | **25** |
| Destination contact/host supervisor | **25** |
| Safety and Security controls/actions to minimise risk | **24** |
| Indemnity | **24** |
| Next of kin/emergency contact | **23** |
| Activities that will be undertaken | **23** |
| Travel insurance | **23** |
| Pre-checked emergency numbers for destination | **22** |
| Communicable and non-communicable diseases | **21** |
| PEP (Post-Exposure Prophylaxis) for HIV | **21** |
| Vaccinations | **21** |
| Personal health | **19** |
| General safety issues elective provider e.g. fire, personal security, road traffic accidents | **19** |
| Terrorism controls | **17** |
| Local laws and customs | **17** |
| Natural disasters | **16** |
| Personal mental health | **15** |
| Money and document control | **15** |
| Residential accommodation risks | **14** |
| PPE (Personal Protective Equipment) | **14** |
| Ethics of the elective/destination | **14** |
| Other organisational aspects (logistics) | **13** |
| Risk of discrimination, assault, detention due to age, sexual orientation, disability, gender, identity, religious beliefs, nationality, caste, race or ethnicity | **12** |
| Disaster planning ('Plan B') | **12** |
| Research ethics where applicable | **11** |
| Entry requirements | **10** |

**Table 6: What does your RA ask for?**

### *C. Qualitative Comments:*

1. **How do you train and/or support the individual marking or appraising the risk assessments?**

There were 23 (88%) responses to this Question. Of these, 10 (38%) medical schools described a relatively robust system of marking and appraising the RAs. Responses were particularly individual to the reporting school, so clear theming was not possible.

Some of the processes reported were internal systems that comprised training and delegation of roles while others appeared to access University-wide systems of risk assessment. Some medical schools had systems in place that appeared systematic but might rely on one or two individuals with particular expertise and knowledge that could be less reproducible over time, or when other systems change. Examples included a programme staff member with "*a Masters in International Travel Medicine"*, *"a Senior admin[istration] support [that] has undertaken the University Risk Assessment Course"* and *"…the specialist travel health bit is done by professionals in travel health".*

Seven (27%) medical schools did not have any systematic process in place but would respond to issues as and when they arose on a case-by-case basis. The word *"experience"* featured several times, suggesting the approach is reliant on an individual/or teams past exposure to, and/or engagement with, risk assessment.

Results showed a clear spectrum from 1 (3.8%) stating that: *"All the risk forms (there are 2 parts, supervisor and student) are submitted - along with a protocol as a progression summative assessment point. These are reviewed by members of the elective committee, who have been trained to review them"* - to 6 (23%) reporting there being: *"no specific training"* or support.

In summary, 11 (42%) of medical schools offered reviewers some support including lectures and written material. This group included members of staff who were individually well qualified, but had no formalised systems in place that other staff could utilise. Five (19%) of medical schools had extensive teaching and reviewing systems in place, and 6 (23%) had no formal support.

**Discussion:** This study consolidates, for the first time, items included in 26 UK medical schools' elective RAs with the addition of important items not on the original question list but suggested later. These provide the most comprehensive potential template for an elective RA to be offered in the UK. The overarching aim was to generate a set of recommendations that all schools offering electives could review their programmes against, not just in the UK but beyond, given that electives are a staple feature of many medical curricula globally.
With participation by 26 of a possible 32 medical schools, we consider our recommendations representative.

We propose that Table 6 'What do you ask about?' and its added 'Responder additions' should be amalgamated to form a *comprehensive RA document* that can be used flexibly by schools to benchmark or update their own documentation or risk conversations as desirable.

We documented response frequencies out of general interest of seeing where current consensus lies, however, we resisted interpreting frequencies beyond that. Some schools, for example, offer open boxes for students to self-determine risks, so figures are

indicative, not absolute. We include 2 2023 example risk assessments based on findings as supplementary files (SUPPL1 and SUPPL2, 2024). Schools may prefer to provide a 'given' template or invite students to *self-identify* relevant risks (given that not all risks apply to all types of elective) which can be backfilled from the template - with a supervisor - to pick up on omissions.

The spirit of this consensus study was prospective rather than retrospective, as an example of shared endeavour to inform future practice, thereby benefitting students by giving them more robust direction on anticipating risks before departure.
The timing and duration of the elective are important in terms of RA. In many schools, the insurance premium paid by the university to its insurer could be influenced by this. For example, southern hemisphere electives taken in January may have different weather patterns (warmer/hotter) compared to those taken in June/July. Equally, countries that are affected by seasonal monsoons (Vietnam, Thailand, Bangladesh) or hurricanes (Caribbean) potentially pose a greater risk during certain months of the year. Consequently, we did ask respondents about the timing and duration of their electives for context, and as anticipated, found variants too great to quantify meaningfully. We have taken a neutral position that there is no need for electives to conform systematically across medical schools. The spirit of electives is, after all, student choice, so our findings served only to confirm that different schools offer electives of different duration at different points during their respective programmes, with some during the programme and some after. Some are summative, some formative. Geography and timing during the calendar year also vary, as appropriate to the needs of the individual school. Irrespective of the timing or academic status of the elective, any students venturing to self-arranged placements in new locations are exposed to a degree of risk. By sharing our approaches to risk managing this, we have learned from each other.

We established that it is often the student who is responsible for completing their own RA in 13 of the schools, with remaining schools offering either separate or combined staff involvement. There is an argument for students demonstrating self-responsibility with encouragement to think on what lies ahead - but equally staff involvement can be useful. Taking responsibility is a key requirement of the learning outcomes mapped to *Outcomes for Graduates* (General Medical Council 2018). Checking the completed RA fell predominately to the elective lead as expected. An acknowledged greater challenge ~~here~~ is for leads with larger cohorts, with some reporting 400 or more students.

Results revealed that only four schools routinely ask the elective host to provide an advance RA. With the host's obvious location familiarity, we advise medical schools to be more mindful of including this expertise routinely. There is a caution relating to

host burden (given the amount of goodwill already often required), but that should not be a barrier to a more inclusive approach. Indeed, the elective literature highlights a lack of proactive host inclusion (e.g. Bozinoff *et al.,* 2014; Kumwenda *et al.,* 2015) in the planning, executing, resourcing and evaluation of elective experiences. The MSC Electives Committee advocates change on this point. For some universities, confirming the insurance requirements with the host is a mandatory part of the RA process.

We note that some schools do not risk assess research. We were not able to interrogate responses in sufficient detail to establish whether this is an omission or simply because those schools' electives do not involve research. The detail required would relate to nature of the research being undertaken with risks to participants, disruption to data collection, failure to achieve approvals in time and so forth being as fundamental for electives as for any other research endeavour.

Resources for supporting RA's were considered, with "online resources" dominating followed by some schools providing an "elective pack" (which could include websites). A future exercise collating a rich resource bank of online and other resources that individual schools have found helpful, to share with each other, could have value. The world changing at pace does raise the issue of keeping any such resource bank up to date, and collectively managing it. Whilst this would be challenging, if achieved this might include other guidance, such as managing unconscious bias, cultural (ethical and legal) context, and inclusivity.

The finding that 14 schools do not "close the loop" was interesting. The variance in electives, the nature of student selection, in formative versus summative experiences and challenges faced in resourcing, might account for the lack of explicit debriefing about perceived versus encountered risk. It is possible that in many schools this does take place, but as part of a more general debrief, with the supervisor as opposed to a specific encountered risk debrief. Nonetheless, a less ad hoc approach would be useful to include because it may improve the students' awareness of perceived and actual risk (which could enhance the student's reflection and subsequent travel organisation) whilst also aiding elective leads with planning for future electives. This could be achieved by asking the debriefing staff member to include it, resources permitting.

The list of suggested RA items provided in the survey was generated by discussion at an MSC Electives Committee meeting and reviewed ahead of data collection. It was surprising; therefore, how many additional items were suggested during the subsequent data collection. This confirms the value of this type of exercise, as the process of each school completing the survey and adding further comments challenged the earlier assumption that schools were all doing broadly similar things. It is interesting

that no single item was reported as an inclusion by all 26 schools. The top three – contact details, destination address and destination point of contact/host - were each reported by 25 of the 26 schools. Other anticipated essentials such as indemnity, insurance, next of kin and activity level, were included by 23 schools. The lowest frequencies of included RA items related to discrimination and disaster planning (12 schools respectively), research ethics where applicable (11 schools) and entry requirements (10 schools). The fact that none of the suggested RA items generated fewer than 10 confirmations of inclusion, indicated a moderate level of consensus.

The more interesting finding was the responder additions. Potentially one or two of these, such as religion (access to worship abroad) and HIV prevalence, may be covered by some of the other categories relating to discrimination. We may need to offer clearer direction, for example, students might not intuitively consider physical access to a place of worship under “religious tolerance” unless specifically guided to do so. Recommendations to include isolation/home sickness, and social media appear relevant and current. These are advisable risk considerations if not currently included. Greater attention to student wellbeing, including risk to mental health, is gaining ground and attention in the university sector. The prevalence of social anxiety and loneliness have increased since the 2020 pandemic (Kindred and Bates, 2023) and these can relate to failure to thrive, personally and professionally, and its impact should not be underestimated. Cautions around social media are increasingly important in the clinical communication, ethics and professionalism teaching on undergraduate healthcare programmes. Risks of leaving a permanent ‘footprint’, particularly if deemed inappropriate, are not insignificant, and can have serious consequences. Therefore, use of social media, images and videos on electives are worth drawing learner attention to. There are benefits, particularly in isolated locations and – as we have learned through the current pandemic – ~~so~~ appropriate use remains a consideration.

This study did not look at specific guidance for students with reasonable adjustments. Having said that, anecdotal observations based on the number of students with Learning Support Plans and/or Examination Support Arrangements suggest we do see increasing numbers of students with various special educational requirements and institutes must be cognisant of this to ensure future iterations of RA forms consider such neurodiversity.

On that note the impact of the unprecedented disruption and global health emergency in the wake of Covid-19 cannot be underestimated (Storz, 2022). It emerged during the write-up of this paper and offers a salutary lesson. Previous global health events such as the Ebola outbreak of 2014-16 in West Africa undoubtedly had some impact internally on placements at the time and

associated RAs, but our data revealed that inclusion of new communicable disease outbreaks was not systematic in elective RAs. Covid-19 is likely to change that; we anticipate that all schools will include ‘pandemic contingency’ and alter their risk approaches to include a wider range of location and travel-related risks to self and others. The decision to publish this report now, rather than re-run the study on the basis of past disruption to timeline, is to inform the RA process and re-evaluate going forward.

In our results section, we collated the free-text comments offered by respondents. As anticipated, most were programme specific, with only a small number of common themes identifiable. The sections were about context, in particular the level of training and support available for those responsible for reviewing and/or signing off elective RAs. For some this feels like a weighty responsibility, particularly given the impossibility of any individual being expert on every one of the many destinations on offer to medical students.

It is not possible to eliminate all risk, but we can (a) be more robust in the way we invite students to reflect on and research risk ahead of travel, and (b) better support the staff guiding these processes. Under half of responding universities described a reasonably systematic approach to appraising RAs. While some referred to over-arching established university systems, the level of transparency and/or access to expertise is likely to vary between institutions.

There are companies that will organise electives for students in given locations. In simple terms, some work rather like package holidays in that the student pays a fee and arrives at the required location for an elective that has been planned for them. This can be problematic, based on reduction in student effort, bypassing the experience of actually organising and executing a project. Parity is a further consideration given commercial electives are more accessible to wealthier students. Whilst companies should risk assess their placements, our study was focussed on the internal RAs undertaken by the students’ base university because that institute still has a duty of care to the student given the placement is part of that course.
On that note, one of the electives committee members had direct experience of students being asked to waive their right to sue an elective host institute should any adverse event occur at that institute. This was a blanket waiver that would have stopped the students suing for negligence if they were injured whilst at the host institute. As such, this waiver was not signed because of duty of care to the student.

Risk assessment support can be ad hoc, by chance rather than design, and dependent on the particular personal expertise of the staff member(s) leading the elective at the time. Some coordinators/administrators may be familiar with university RAs and have undertaken training. An individual staff member supporting electives may hold

a qualification in, say, global health or travel medicine. However, for many programmes this is not the case. Although elective roles might attract people with specific interest/expertise in international health, our survey indicates this is not always the case.

Where the elective is a Student-Selected Component, roles can be informally recruited or inherited, and electives can receive less central support than the more “core” clinical counterparts. This, as well as the support offered to students, needs further work and consideration. A current prerogative for the MSC Electives Committee is championing the status of the elective, its ethical positioning, and formalising its requirements without increasing the bureaucratic burden and concomitant loss of the core elective ideals of flexibility, choice and freedom.

**Conclusion:** In summary, convergence of thinking on core components of RAs and the process of sharing internal processes and ideas can give elective leads confidence and direction in the approaches they are taking.
Risk assessment differences reported can be due to cohort size, maturity of the institution and its system, or the clarity of the survey questions. We recognise the highly individual nature of electives, and design flaws, as limitations to this project. For example, some responses could be attributed to the question not being adequately worded to have apparent direct relevance. The strengths of the study are its uniqueness in offering a consolidated set of recommendations easily transferable to all institutions offering an elective, and the potential benefit to both elective staff and departing students of having a stronger framework for advanced risk preparation. This could contribute significantly towards student and patient safety and help guide the development of elective programmes at the new emerging medical schools.

## Recommendations for Medical Schools Arising From this Study:

1) Develop and introduce a standardised risk assessment form for electives (see supplementary data files 1 and 2).

2) Ensure time is allocated within the curriculum for students to be introduced to risk assessment where likelihood of risk assessed versus actual events encountered can be discussed.

3) Provision of adequate numbers of trained staff to support risk assessment compilation and assessment.

4) Institutional resources permitting, any current post-elective student de-brief should include a review of those risks assessed versus those risks encountered.

5) Future iterations of institutional travel risk assessment forms must be cognisant of the increasing number of students with various special educational requirements

to ensure such students have assessed how they will continue to access necessary resources/support whilst on placement at the host.

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