

## Editorial

Looking at our first issue for 2019, it is clear that educating health professional students necessitates learning an increasingly wide range of skills and providing rich learning opportunities. Educators are acutely aware of the increasing expectation that pre-entry education will not merely facilitate students to meet the graduate competencies of our professions, but also actively promote their employability and career capability to meet the demands of a future-focused workforce. For health professional educators, it's an exciting, if somewhat daunting, prospect.

Universities are responding to their ever-expanding remit by becoming more student centred, listening to and partnering with students to provide global experiences, volunteer work and exposure to vulnerable populations. Furnishing such opportunities means expanding the range and nature of clinical and professional learning options available to promote: self-awareness as a practitioner, interprofessional behaviours and a deep understanding of person and community-centred practice.

In this issue, Moore and Campbell demonstrate the innovation and creativity of educators in meeting this challenge by designing an interprofessional learning experience using an escape room scenario. Rombola highlights the importance of a client-centred practitioner understanding spiritual history. Other papers exemplify student-centredness by focusing on the personal experiences and support needs of our students, investigating meditation and mindfulness for medical students (Bailey, Opie, Hassed, & Chambers) and stressors experienced by oral health students (Olson, Beckett, Adam, Tawse-Smith, & Moffat).

Another wide-ranging university response to provision of diverse clinical and professional opportunities for students is the growth in university health clinics, and particularly student-led clinical services within these settings, discussed in a recent issue of FoHPE (Moore et al., 2018). These authors described the aims of a hot topic action group (HTAG) to “explore and enhance educational outcomes from this setting” (Moore et al., 2018, p. 1) by investigating their costs, benefits and challenges, and subsequently developing a quality assurance framework.

Moore et al. (2018) identified the potential for university clinics to provide best practice, research-informed clinical teaching and learning that can effectively support at-risk students and advance interprofessional training, but acknowledge the lack of current evidence that these outcomes are being achieved. While a number of research studies indicate student- and educator-perceived benefits to student competence (Schutte et al., 2015; Copley et al., 2007), challenges to achieving the full educational potential of university clinics include establishing funding models that acknowledge the time required for teaching and learning, attracting and training clinical educators, and ensuring clinical education models and processes equip students for the current and future workforce (Moore et al., 2018).

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As an academic previously charged with the responsibility of establishing and managing a university clinic for 15 years, I have experienced firsthand the impact of varied funding models, staffing structures, placement models and pedagogical changes on student education within university clinics. The satisfaction of building and sustaining interprofessional clinics, developing multi-year student mentoring clinics and designing novel supervision models to cater for large student cohorts and part-time staff did not come without challenges. Financial sustainability and the structures required for academic institutions (not originally designed for this purpose) to deliver student-led clinical services have been constant themes in my communications with counterparts across different university settings, and across different countries. The paucity of research evaluating university clinics does not surprise me, given that those best placed to conduct such research (university academics with research responsibilities who are also clinical educators within these settings) are few in number and, where they exist, are juggling the demands of a clinical caseload and student education within a business model. I recall attending an interprofessional health conference in 2007 and discussing these issues with a Canadian colleague managing a recently commenced university clinic. She had a wild-eyed, overwhelmed look in her eyes I recognised from my own experience, borne of a commitment to student education, a vision of what university clinics could be and a determination to make it work within the available resources. I have seen the rise and fall of many university clinic services across a range of institutions, and some that have sustained.

Moore et al. (2018) rightly suggest that a long-term commitment from universities is required to realise the educational potential of university clinics, in the form of, for example, a dedicated academic leader to champion clinical education and adequate time to design and evaluate university clinic practices. To take this further, and to ensure that sound theoretical learning and practice frameworks are truly implemented into ongoing day-to-day university clinic practice rather than being short-lived project-based initiatives, what may be required is an intentional focus at the teaching and learning coalface—university clinical educators.

Moore and colleagues (2018) also acknowledge the benefits of engaging experienced practitioners as clinical educators but also express the need for staff training in clinical education practices. This need cannot be underestimated when one considers the context in which education occurs in university clinics. Supervising high student numbers (e.g., 4–12 simultaneously), constantly having dual responsibility for students and clients, frequently supervising at-risk students and the unaccounted supervision time that results from these demands were identified as contributing to clinical educator burnout, more than 15 years ago (Copley et al., 2007; Reeves, Freeth, McCrorie, & Perry, 2002). Add to this, the increase in casualisation and contract-based employment in the university sector, and employment of clinical educators in administrative/professional categories rather than academic roles in some universities, and it is clear why adequate quality training in clinical education practices remains elusive—lack of a career path limits staff retention and long-term skill development. Most educators would agree that teaching and learning is a specialised skill over and above discipline-specific professional experience. Given that clinical educators have a key role in facilitating

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students' pathways from curriculum to employability, the continuing professional learning pathways developed for university teachers need to consider the particular needs of clinical educators.

Unlike previous decades, when universities may have considered clinical services an income-generating proposition, there is now growing recognition that funding models must adequately account for teaching and learning time. When considering the recent progress of interprofessional clinics, such funding will need to cover not just student guidance and feedback but opportunities for clinical educators to model interprofessional behaviours to students (Hill, Nelson, Copley, Quinlan, & White, 2017). Interprofessional clinics should also consider the varying ways in which different disciplines might work with different client groups, and implications for student supervision and clinical educator time, e.g., group physiotherapy programs for adults compared to individualised occupational and speech pathology sessions for children with autism and challenging behaviours.

It is assumed that service provision and models of supervision in university clinics will be informed by research evidence and that they provide a means of teaching students private-practice business models (Moore et al., 2018), a major benefit at a time when universities are championing student entrepreneurship. My own experience suggests that these assumptions can only be realised if there is intentional integration of the clinics within curricula and research programs (as occurs in other clinical services with embedded clinical research positions), with academic and clinical educator partnerships central, rather than clinics operating as separate business-driven entities.

More than ever before, university clinics provide a golden opportunity to exemplify the clinical education practices that will produce a health workforce well equipped for the practice landscape our graduates are entering. Examining the bold innovations, mistakes and successes that have emerged from these settings over the past two decades might help us make this opportunity a reality.

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