EDITORIAL

Same—same but different: How allied health contributes to health professional education

Educational scholarship and innovation in medicine and nursing have dominated the health professional education (HPE) landscape for many years. Scholarly contributions from the allied health professions are increasingly adding to our understanding of HPE and how it occurs across not only different professions but also in different contexts. As allied health professionals, educators and HPE researchers (and associate editors of FoHPE!), we are acutely aware of the need for professions to explore their educational practices and the unique opportunities for allied health to lead this research.

Unlike medicine and nursing, allied health professions are relatively new and are a group of professions with varied therapeutic aims and methods (Institute of Medicine, 1989). The professions include, amongst many others, audiology, chiropractic, dietetics, occupational therapy, osteopathy, pharmacy, radiography, physiotherapy, psychology, podiatry, speech pathology and social work (Department of Health and Human Services, 2016). The breadth of professions, areas of practice and associated patient presentations is a strength of the allied health professions. We argue this strength flows into education research that has applicability across all HPE contexts.

Educational models in allied health offer opportunities to explore novel approaches to clinical learning. Clinical placements for preregistration allied health students are exceptionally varied with respect to learning environment (hospital, community clinic, student-led clinic), duration, clinical educator to student ratios and different workplace-based assessment tools. In this edition of *Focus on Health Professional Education* (FoHPE), we see a variety of strategies that can assist in the preparation of students for placements in podiatry (Reynolds & McLean) and dentistry (Nilsson, Young & Croker) and, potentially, how improved simulation fidelity may enhance preparedness (Bridgman & Hughes). Further consideration could be given to supervisory models incorporating peer-assisted learning, for example, which can enhance student confidence and decrease supervisory burden (Sevenhuysen et al., 2017). These variable educational scenarios have allowed allied health to make significant contributions in informing our understanding of clinical education. Below, we highlight three key areas of the allied health literature: interprofessional education, preparedness for placement and development of high-quality clinical education faculty.

Interprofessional education is recognised as essential for whole-person patient-centred care across the patient journey. The care of patients with chronic diseases is where allied

health plays a particularly significant role. The success of individual patient care relies on an interprofessional team, and allied health professionals make up a significant number of the healthcare team. Partly due to their relatively smaller numbers, allied health professionals consistently engage in interprofessional practice, leading to strong educational innovations in interprofessional learning programs. Allied health student training emphasises care across the patient journey, from primary to tertiary care. This entails navigating services, interprofessional communication and a deep knowledge of healthcare service provision. FoHPE provides an avenue for this research to be disseminated. For example, Foley et al. (2019) describe an interprofessional learning program to address gaps in healthcare for vulnerable Indigenous children, while Moore and Campbell (2019) designed an interprofessional escape room. (FoHPE is now calling for original research articles on interprofessional learning, to be published under a special theme from mid-2022 to early-2023. See the FoHPE website for details).

Variation in allied health placement settings and supervision models requires consideration of student preparedness for placement. For allied health educators, these varied settings present a challenge for student wellbeing, educator workloads and optimisation of the placement experience. Clinical educator perceptions of student preparedness influence attitudes towards student placements and working with students. Allied health research has revealed interesting variations in perceptions (Gibson, Dart, et al., 2015). These works highlight opportunities for improvement in student preparedness, with educators particularly valuing high levels of communication skill, as can be found in this issue in Reynolds and McLean's article about supervisors' perceptions of podiatry students and graduates. Allied health student placements can go beyond just providing learning experiences and contribute to healthcare delivery, including performing risk screening activities in their initial placement weeks (Gibson, Golder, et al., 2016) and providing direct patient care as they become more proficient (Furness, 2021). Optimal preparation of students for placement is paramount in allied health given the majority of their clinical and professional skill development occurs in this setting, with few professions offering or requiring internships on completion of preprofessional training. We see research into student placement preparedness in allied health as an opportunity to inform how all health professional students are prepared to engage in clinical learning, potentially easing the supervisory burden. In this issue of the journal, we draw attention to the work of Kumar, King and Seymour-Walsh on conceptual thresholds as a way of framing this research and May, Young and Gillman, who outline their use of concise eLearning for continuing professional development for educator preparation.

Allied health supervisory models tend to have more intensive student to clinical educator ratios, with educators often supervising one to three students over a number of weeks. The lack of internships in allied health programs often necessitates the attainment of competency by the end of the students' final placement, with total placement experiences

being approximately 20 weeks for many professions. During this time, allied health clinical educators are required to guide, mentor, support and assess students to reach entry-level proficiency. As such, they need to have high-quality educational skills (Gibson, Porter, et al., 2019). Due to these demands of expertise, allied health educators require support and professional development, which is not always accessible given the unclear career education-focused pathways and lack of financial support to undertake this development. We contrast this with current structures in medicine and nursing. Our vision is for a future where allied health clinical educators have fully-funded, defined roles with ongoing professional development support and career advancement pathways based on education and supervision.

Also in this issue, Farlie, Johnson, Wilkinson and Keating expertly explain the use of Rasch analysis in HPE and research, as part of our regular Focus on Methodology series, and Danielle Ni Chróinín offers a fantastic poem on the pandemic's impact on HPE. Whilst we are all health professionals, the differing contexts in allied health provide a richness that can only help improve our understanding of how best to educate our future health workforce. Same—same but different.

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