

Clinical Education for allied health students and Rural Clinical Placements

Services for Australian Rural and Remote Allied Health

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Clinical education and rural placements – Clinical placements as part of the clinical education of allied health professions is in crisis in remote and rural areas.

- **SARRAH calls on the Australian Government to ensure that universities are adequately funded to meet the real costs of educating an allied health professional. Any increase in funding to the universities to overcome the current situation must be directed into meeting the clinical education requirements.**
- **SARRAH recommends expansion of the University Departments of Rural Health (UDRH) program to cover all remote and rural Australia. UDRH resources should be enhanced with core funding for: allied health academics on staff, con-joint appointments of, academic/clinical staff, training of clinical supervisors, and support of Allied Health Clinical placements.**
 - i. **Universal access to UDRHs across remote and rural Australia.**
 - ii. **UDRH structures to support all allied health professionals in the region irrespective of those courses provided by the parent university.**
 - iii. **\$200,000 per UDRH as part of core funding for allied health academic positions.**
- **SARRAH seeks a direct Commonwealth funding initiative to support allied health clinical education and professional placements in rural and remote communities.**
 - i. **Accommodation infrastructure for students.**
 - ii. **Support for Allied Health clinical placements to match that of medical clinical placements to ensure students living away from home are not disadvantaged by cost of travel and accommodation.**
 - iii. **Rural Clinical Placement Scholarship Scheme Submissions being prepared by SARRAH (Funding proposal has been prepared by SARRAH for submission to the Department of Health and Ageing. Funding proposal considers 4 options. Request for \$800,000 per annum)**

Clinical education and rural placements – Clinical placements as part of the clinical education of allied health professions is in crisis in remote and rural areas.

Principle:

The focus for the education and training of entry level health professionals is ultimately to improve the health and well being of all Australians. Any changes to mechanisms for the funding and delivery of entry level health professional education need to be made with the overall goal of improving the health care for all Australians. Consideration needs to be given to the special needs of rural and remote communities; Indigenous; and other culturally diverse people within the Australian population whose health needs must be catered for.

Transition from entry level student to practicing health profession can be improved by ensuring that allied health professionals have adequate levels of clinical exposure in their undergraduate or postgraduate entry level years. However, current funding levels do not allow the universities to adequately fund clinical education. Conversely, the states (public hospital and community health facilities) believe that students place additional burden of responsibility and that the funding for their support should be provided by the universities ⁽¹⁾

Current issues impacting on the provision of clinical education for the core allied health professions:

- a) The Higher Education Support Act 2003 which underwent a review at the start of 2007 resulting in a change in the cluster under which allied health courses are funded and a 25% increase in funding. **However, whilst the funding has been increased, there is no indication that the universities have been directed to put the additional funds into the provision of clinical education and student placement support.**
- b) Coordination for clinical education:
 - i. Clinical coordinators who work with the student and with facilities to provide clinical placements to coordinate clinical placements. The coordinators are university based. Funding constraints at universities have led to the withdrawal of such dedicated positions, increasing the demand on teaching staff and students to organise clinical placements.
 - ii. A specific focus is required to coordinate placements in rural and remote locations. Rural clinical coordinators who can work with all universities (through their clinical coordinators) within the state and with providers of clinical placements to organize placements for students, work with students to organize travel and accommodation to placement, and provide support for clinical supervisors (education, training, academic, liaison between supervisor and university, establish outcomes for placement, troubleshooting). This is particularly important in the Northern Territory and Tasmania to bring students in to for clinical education where there are no locally based schools for the allied health disciplines. The ability to experience the work environment is diminished in both Tasmania and the Northern Territory due to this lack of coordination. Whilst some University Departments of Rural Health work with allied health students to undertake a rural placement this is not uniform across the UDRHs nationally.
- c) Limited funding support for students who cite financial, employment and family as issues to be considered when nominating sites for clinical education⁽²⁻⁵⁾. Rural placements place increased financial demands on students requiring travel and

accommodation at location. Loss of income from inability to meet employment commitments and payment of rent for accommodation where attending university. Periods away from metropolitan base may result in loss of casual employment position as workplace does not have any requirement to hold position open, or in student incurring higher transport costs if they are in the position to travel back to metropolitan area to work at weekends. There is major disparity in the level of support available to medical students and to allied health students^(4, 5) with the majority of medical students having costs of rural placements (92% accommodation, 75% travel) met, whilst it was considerably less for allied health (56% accommodation, 28% travel), with great variation from state to state. Access to appropriate accommodation is a major issue. Coordination between professions (including medical and nursing) to ensure that all students undertaking simultaneous placements are appropriately accommodated is not provided, resulting in perceived favoritism for medical students⁽⁶⁾.

- d) Funding support for clinical placement – education and training of clinical supervisors, liaison with university, backfill, loss of income (private practitioner), resource requirements – access to IT, teaching resources, simulation devices. Allied health students see the evidence of support provided to medical students in the setting up of Rural Clinical Schools providing all infrastructure support required for long term clinical placements. In rural and remote areas where clinical placements occur, there is often ad hoc liaison between those providing the clinical supervision and the university. Inconsistent training and mentoring for the supervisor, lack of recognition of the impact on normal clinical workload and lack of backfill, the effectiveness of the communication channels between the university and the supervisor (or lack of) impact in particular on the quality of placements in rural areas.
- e) Most clinical education for allied health professionals is delivered within the public health system – public hospitals and ward setting and in community settings. As such, the provision of clinical education has been the responsibility of the State.
 - i. Opportunistic – contact made by student and/or clinical coordinator (where such as position exists within the university). Often multiple contacts from multiple universities. Difficulty in finding health facilities willing to take students now means that often contact may be made from interstate universities. There is no guaranteed commitment from the public health sector to the provision of clinical education for allied health professionals – just an expectation which often due to budget and staff constraints cannot be met. Increasing the number of university places for health professionals has increased the requirement for clinical training places which has not necessarily been accompanied by planning for the clinical placements or an increase in clinical educators/supervisors. Additional clinical placements are being sought for graduate entry programs. Evidence from Queensland where physiotherapy departments in public health settings refused to take physiotherapy students for clinical placements resulting in a major crisis.
 - ii. Expectation on public sector allied health staff that they will provide clinical education for students in their discipline.
 - Not an integral part of health professional education and training at an entry level. Such education and training needs to be provided in the most appropriate manner post graduation (face to face, videoconference, online, CD-Rom and other published resource material). Such training support needs to be ongoing. However, many allied health professionals do see the need to supervise and

educate students as critical to the future of their profession and as an integral role for qualified practitioners.

- Staff turnover impacts on the ability to provide quality student placements. A staff member may have been provided with the necessary training to become a clinical education supervisor and then leave the position. The resultant vacancy and need to recruit and train the replacement may have significant impact on the facilities ability to provide a quality clinical experience for students on placement.
 - Time consuming for the supervisor – Teaching and supervising students has a direct impact on the amount of time a practitioner can provide services⁽⁷⁾. There is often a lack of support from management regarding the time cost of providing clinical supervision. Staff are often still expected to carry a full client workload in addition to their duties towards the students. Minimal provisions for backfill. (Cockfield, Toowoomba time and motion study – 7 physiotherapy students working in various settings within Toowoomba base hospital – large regional setting – 1.5 FTE required to provide backfill to cover workload and clinics which were cancelled as a result of student supervision requirements)
 - Increasing cost and demand for public health services resulting in pressure on the budgets of facilities that have traditionally provided clinical placements for allied health students. Workforce shortages are adding to pressure being place on facilities that previously were willing participants in providing clinical placements. Public sector administration reacting to the increased pressure on their budgets by focusing on the delivery of clinical services. If a public health facility has had a position for a clinical coordinator/student supervisor this position may be withdrawn, may be left vacant or the filled with a professional to provide clinical services to meet demand rather than supervision services.
- iii. Issues for clinical placements in the private sector:
- Loss of income for the supervisor and lack of support – both financial and non-financial
 - Private practitioners are also limited by current indemnity and infection control protocols to provide students with observation only placements, limiting a student's opportunity to learn.
 - Allied health services that are funded by either the patient, or by Medical Insurance places demands that the patient will be treated by the registered practitioner.
 - With increasing demand on the public sector, the private sector and allied health professionals now working in practices that have been funded by the Australian Government provide an opportunity to expand the clinical experience of allied health students. This will not occur unless properly resourced.
- f) Variation in quality and quantity of clinical skills to which the student is exposed. There may be differing clinical placement models and differing perceptions between universities and service providers about the purpose of clinical education. The skills base and teaching experience of the supervisor and learning outcomes for the placement impact on its quality. The impact of increase demand

- for the delivery of services and other demands on the supervisor impact on the ability to spend time teaching⁽⁶⁾.
- g) Variation in the support provided to the supervisor of the student. Varied expectations of the supervising health professional from their employing institution and the university, the requirements for ongoing learning and professional development from the supervisor may be limited in access. If taking students from different universities, the supervisor will need to be across the variable training and assessment requirements for the clinical experience.
 - h) The high turnover of allied health professionals in rural and remote communities means that there is a problem with finding experienced practitioners able to take students. Often, supervision when a facility agrees to take a student will fall to a developing practitioner with less the 2 years experience in a rural setting.
 - i) Increased numbers of courses and university places for allied health students has resulted in increased demand for clinical placements. This increased demand has added to the pressure on the public sector facilities and emphasized that lack of coordination, planning and financial support for clinical education. The shortage of locations for clinical placements in metropolitan areas due to the demand from rising numbers of students and workforce shortages have led to placements occurring in rural areas that are not rural in focus. The evidence suggests a good quality rural placement and rural clinical experience can influence a student to take up a rural health career (John Flynn scholarship program). The requirement to undertake a specific skills based (non-rural outcome) clinical placement in an a rural location has the potential for negative impact both in terms of specific skills component (the placement occurring in a setting where the supervisor is a rural generalist rather than a specialist in the area of the clinical skills component) plus providing negative rural experience for the student.
 - j) Delays in student graduation to allow students to undertake the necessary clinical education components. Is increasingly reported in submissions to the Australian Government by professional associations such as the Australian Physiotherapy Association.

Clinical Placements

Undergraduate and postgraduate entry level courses should provide a broad base from which the allied health professional graduate can develop a career, becoming a leader for the profession on whatever clinical practice pathway they chose. Hands-on clinical experience is an integral part for the core allied health professions, as it is with nursing and medicine. It is this 'real' setting that provides the student with experience in clinical, moral and ethical decision making⁽²⁾. Students require the time and support to enable them to gain this clinical experience. This is essential if the current status of graduates from allied health courses being considered fully qualified is to continue. Students should be included as members of the clinical team wherever possible, be assigned an appropriate level of responsibility, and be actively included in the team's educational and review activities. Not only does this provide students with the learning opportunities that they need to develop their clinical knowledge, it also demystifies that function of the unit team, better preparing students for their first day of professional practice.

Clinical education as an integral component of the undergraduate education of the allied health workforce has been recognised by the Productivity Commission⁽⁸⁾ in its research paper on the Australian Health Workforce. This paper recommends the review of the clinical education requirements and funding of the health professional workforce.

Rural clinical placements

Entry level course curriculum for allied health students must provide a rural health subject with a mix of theoretical and practical content as part of the core curriculum for all students. This content must include aspects of Indigenous health and cross cultural awareness. Those students with an interest in rural clinical practice must be encouraged and supported to undertake a rural clinical placement^(4, 5). Such placements must have high merit within the structure of the course, with clear outcomes for the development of skills and knowledge specific to rural health for that discipline. The rural placements need to be accessible, well coordinated and well supported to be successful. This need is recognised for medical students through the Rural Undergraduate Support and Coordination Program, funded through the Department of Health and Ageing. This program provides funds direct to the universities specifically to enable a focus on rural curriculum, rural placements, and enrollment by rural students into medical courses, support for rural clinical supervisors.

Existing rural infrastructure for medical students must be funded/resources to provide similar programs for allied health students (Scholarships, University Departments of Rural Health, Rural Clinical Schools). This is in recognition of the importance of primary health and multidisciplinary team health care and of the role that allied health professionals fill in their delivery.

Clinical education requirements by the professions

The clinical allied health professional associations sought information from the universities regarding the real costs of providing the necessary education for students to graduate across the range of disciplines. SARRAH sourced information directly from the professions regarding clinical education requirements. There is variation across the disciplines in both the number of hours required and in the method and timing of clinical education for the students. The true cost of educating each student is put at between \$15,000 and \$28,000 per annum by the universities⁽⁹⁾. The costs reflect the differences in the delivery of clinical education and the requirements to achieve core competencies by undertaking a minimum number of hours of clinical education. Requirements for clinical education for many of the professions range from 1000 to 1500 hours.

Clinical placements provide the student with fieldwork experience regarding the development of clinical skills, clinical reasoning, decision making (clinical, moral and ethical), developing interpersonal skills, communication and practice in a multidisciplinary environment. The classroom setting and computer simulators do not provide for the development of such skills.

Clinical placements may occur in tertiary hospitals but extend to regional and rural hospitals and community settings for many of the professions. Some professions, limited by the private sector placements being observation only, provide clinical experience through costly on-site (university campus) clinics.

Funding for clinical education

Increased funding – appropriate to the actual clinical education requirements and costs for each of the allied health disciplines providing clinical education – will enable:

- a) Coordination of clinical education placements
 - i. University based clinical coordinators
 - ii. Rural clinical coordinators / rural allied health academics – assist in the organisation of rural clinical placements for all allied health

students, provide support for practitioners working as clinical supervisors, provide link between supervisor, student, university based clinical coordinators and university school, deliver cross cultural training where placement involves indigenous communities, provide education and training to rural supervisors.

- b) Provide financial support for the student to assist with the costs of the clinical placement – of particular importance for rural and remote placements.
- c) Increase the number of clinical supervisors in the public and private sector who are able to provide the supervision and education necessary to meet the outcomes for a clinical placement. By increasing the numbers of clinical educators and providing them with necessary support the availability of quality clinical placements will increase.
- d) Ensure specific rural practice outcomes for rural placements as well as outcomes relating to clinical skills (e.g. cultural awareness, life survival skills, communication, network building, community needs analysis, community capacity building, leadership and advocacy, management).
- e) Provide all staff responsible for clinical skills education of students with access to appropriate educational training.
- f) Facilitate the appointment of clinical supervisors as a member of the university staff – providing them with access to education and training and to university IT, email and library services.
- g) Provide financial support for the facility providing the clinical placement – meeting legal requirements (insurance, infection control); education and training for supervisor, backfill and reducing loss of income for private practitioners. This would open up the opportunity for clinical placements to occur in private practice, reducing the burden on the public sector and enhancing the learning environments for students. Clinical supervisors need to be recognised, valued and rewarded appropriately
- h) Ensure the clinical education facilities meet standards as required by the profession by regular inspection as part of the course accreditation process.

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