Supporting allied health students during rural placements: Perspectives of students and clinical educators

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Developing strategies for sustainable and successful allied health student placements in rural settings is imperative to fostering a robust and resilient health workforce. This study aimed to explore support needs for allied health students on rural placement in Australia, from the perspectives of students and clinical educators. A total of 13 students and 11 clinical educators completed semi-structured interviews. Thematic analysis of data was undertaken. Participants were allied health students completing an Australian rural clinical placement, and clinical educators of allied health students in rural Australian locations. Disciplines were physiotherapy, occupational therapy, speech pathology, dietetics, and exercise physiology. Three main themes were generated, indicating that support provided may be: i) flexible and adaptive, ii) bespoke to rural practice, and iii) within a culture of teamwork. Rural allied health placements necessitate unique strategies to support student learning, facilitated through actions of both the clinical educator and the broader health care team.

Keywords: Allied health students, rural, support, clinical placement, qualitative

In the Australian healthcare system, the provision of allied health services to rural Australia has been identified as a nationwide priority (O'Sullivan & Worley, 2020; Worley, 2020). Allied health professionals are typically defined as qualified healthcare professionals outside of medicine and nursing, for example speech pathologists and exercise physiologists (Allied Health Professions Australia, 2024). Rural Australia faces a shortage of allied health professionals in comparison to metropolitan regions, with the proportion of employed clinicians per capita decreasing as geographical remoteness increases (Australian Institute of Health and Welfare, 2022). The World Health Organisation has published recommendations to address the geographical maldistribution of health professionals, such as optimizing the education of health professional students as a means of increasing rural service capacity and equipping the future workforce with robust skills for rural employment (World Health Organisation, 2010). Australia has since responded with a series of initiatives under the Australian Department of Health and Aged Care's *Stronger Rural Health Strategy* to 'teach, train, recruit and retain' their rural health workforce, including increasing healthcare student numbers, educating healthcare students within rural regions, and updating healthcare curricula with rural-specific material (Department of Health and Aged Care, 2021). Rural clinical placements are known to increase healthcare students' intentions to work rurally (Durey et al., 2015; Moran et al., 2020; Playford et al.,

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2006), thus provision of rural clinical placements is considered a key strategy to address the shortage of allied health professionals in the rural workforce (Lyle & Greenhill, 2018).

Allied health students undertaking rural placements face multiple challenges. Allied health students encounter many barriers to positive placement experiences, including coping with financial stress, sourcing suitable accommodation, travelling to rural areas, and navigating feelings of personal, social and professional isolation (Adams et al., 2005; Bazen et al., 2007; Campbell et al., 2012; Edmunds & Harris, 2015; Johnson & Blinkhorn, 2011; Kerr et al., 2013; Killam & Carter, 2010; McLennan et al., 2012; Thackrah et al., 2014; Turner & Lane, 2006; White & Humphreys, 2014). Clinical educators also encounter challenges supporting rural placements, including navigating workplace demands with limited staffing and resources (Marlow & Mather, 2017; Zournazis et al., 2018). Provision of support to health professional students during rural clinical placements is known to contribute to positive placement experiences (Marlow & Mather, 2017; Oosterbroek et al., 2017; Smith et al., 2018;). New-graduate physiotherapists in rural settings have voiced their preference for timely and accessible support and mentorship specific to their caseload, even with resource limitations in workplaces (Martin et al., 2021). Furthermore, Walker and Forbes (2022) determined that health student support was best achieved when clinical placement providers and universities engaged in a collaborative, unified approach. Understanding and outlining support needs may provide stakeholders with resources for improved supports at the systemic and individual levels.

Whilst the support needs of medicine and nursing students on rural placement have been explored, the specific support needs of allied health students undertaking rural clinical placements have not been well established. Clarifying the support needs of allied health students during rural clinical placement is a priority, given the large body of research advocating the benefits of positive rural clinical placement experiences, the ongoing maldistribution of rural allied health professionals, and the health discrepancies experienced by individuals living in rural Australia. Therefore, this study aimed to explore allied health students' support needs during rural clinical placements from the perspectives of students and their clinical educators.

METHODS

Allied health students and clinical educators of allied health students were recruited to share their experiences and perceptions of students' support needs for rural placement. Participants were recruited through professional contacts of the research team. Interviews were conducted via telephone and video conference in 2022 and 2023. The study employed thematic analysis (Braun & Clarke, 2022) of interview data. Ethical clearance was obtained from The University of Queensland — Institutional Human Research Ethics, project number 22022/HE000257.

Participants

Student participants were required to have a minimum four weeks of experience within a rural placement prior to being interviewed to ensure that they had adequate experience to reflect upon. Students who were in their fourth week of clinical placement were also included. Rurality of placement was defined using the Modified Monash Model, which classifies regions in Australia with respect to geographical remoteness and town size on a scale of one to seven (Department of Health and Aged Care, 2023). Placement locations were included if they were defined as Modified Monash Model Three (large rural towns) through to Modified Monash Model Seven (very remote communities) (Department of Health and Aged Care, 2023).

A snowballing strategy was used to recruit allied health students and clinical educators of allied health students. Initially, students from The University of Queensland, who were known to have attended a rural clinical placement were emailed via their university accounts, with one email from the lead researcher (RM) inviting them to participate in the study if they met the inclusion criteria. If the student responded, a mutually convenient interview time was arranged. Following the interview, participants were invited to undertake snowballing recruitment of additional allied health students from other universities who were also undertaking clinical placement at their rural placement location. To recruit clinical educators, professional contacts of the research team were emailed to assist with recruitment. If potential participants were identified, they were then emailed by the lead researcher (RM), to arrange a mutually convenient time for an interview. All participants provided written consent to participate in the research.

Data Collection

Semi-structured interview guides were created for allied health students and clinical educators of allied health students. Example interview questions are provided in Table 1. A total of 13 allied health students and 11 clinical educators of allied health students (Table 2) were interviewed about their experiences of rural placements. Interviews were conducted remotely by telephone and videoconference, with an average interview time of approximately 20 minutes. Interviews were recorded and were transcribed verbatim with minor edits for readability and clarity. All participants were provided with an opportunity to review the transcript of their interview via email. No changes were made following member checking of the data. Recruitment and data collection continued until data sufficiency was determined (Braun & Clarke, 2021). Malterud et al.'s (2016) framework of information power was used to guide the authors' decisions regarding the sample size required for the study and when to cease recruitment and data collection (Malterud et al., 2016). Information power is a tool to guide required sample size in qualitative research and suggests that the higher the information power of a sample, the lower the sample size required. The current study was assessed by the authors as having a specific aim which increases information power. Simultaneously, the study had a wide range of geographic locations and allied health professions, and a lack of previously established theory which decreases information power. The authors perceived that information power had been achieved given the quality of the dialogue in the interviews and the aims of the study being specific to allied health students, rural clinical placements, and support needs.

TABLE 1: Example interview questions.

Questions for allied health students	Questions for clinical educators
1. What has been your experience of rural placement? 2. Where there any parts of rural placement that you were surprised by? 3. Where there any parts of rural placement that you struggled with? 4. What kind of mentorship and support has been helpful during your rural placement? 5. What would be the ideal mentorship and support from your clinical educator during rural placement? 6. Do you think that you were adequately prepared for rural placement? 7. Do you think that universities should contribute towards preparing you for rural placement?	1. What has been your experience of supervising students on rural clinical placement? 2. What, if anything, do students struggle with on rural placement? 3. How do you support students on rural placement? 4. Do you think students are prepared for rural placement? 5. What do you think that the expectations of students should be when they arrive for rural placement?

TABLE 2: Demographic details of the sample.

Demographic	Student (n=13)	Clinical Educator (n=11)
Gender *(n (%))*		
Female	9	11
Male	4	0
Age range (Mean)	23.9 years (range 20-33)	-
Discipline *(n (%))*		
Physiotherapy	10	6
Occupational Therapy	0	1
Speech Pathology	1	1
Dietetics	2	1
Exercise Physiology	0	1
Pharmacy	0	1
Degree Level of students *(n (%))*		
Bachelor Entry	11	-
Master Entry	2	-
Setting of Placement *(n (%))*		
Public Hospital	11	10
Private Practice	0	1
Aged-Care	2	0
Placement Location (Modified Monash Model) *(n (%))*		
Large rural towns (Modified Monash Model 3)	3	1
Medium rural towns (Modified Monash Model 4)	3	4
Small rural towns (Modified Monash Model 5)	2	1
Remote communities (Modified Monash Model 6)	3	4
Very remote communities (Modified Monash Model 7)	2	1

Data Analysis

The data were subjected to reflexive thematic analysis as described by Braun and Clarke (2022), which involved a process of generating meaning from qualitative interview data, theoretical knowledge and researcher subjectivity. Two researchers (RM/SW) undertook the analysis process independently to contribute to the reliability and transparency of the results. The student and clinical educator transcripts were coded together as one data set. The lead researcher (RM) is a physiotherapist who works as a lecturer and a clinician in regional Tasmania. The second researcher who undertook the analysis (SW) is a physiotherapist and PhD student in Queensland, who has experience working as a physiotherapist in regional Queensland. Both researchers have published research relating to new-graduate support needs. Both researchers undertook the process of epoch prior to starting the analysis process to ensure that they identified their previous beliefs regarding the phenomenon (Moustakas, 1994). To familiarize themselves with the data, one author (RM) conducted all interviews, and the other author (SW) transcribed all interviews. Both authors reviewed the transcripts and noted initial codes of the intended meaning voiced by the participants. The researchers met on two occasions to discuss their interpretation of the data, and to identify patterns of shared meaning between the researchers and patterns of shared meaning amongst the participants. The researchers then sorted these codes into themes and refined and define the themes (Braun & Clarke, 2022). At this point, the full research team reviewed the draft results, which is a team that includes a rural clinician, two university placement coordinators, and academic staff from two universities. Multiple attempts were made to maximize the reliability, trustworthiness, and integrity of the analysis process (Braun & Clarke, 2022) including adherence to the interview guide, the audio-recording of all interviews, two researchers undertaking the analysis process independently, and member data checking.

RESULTS

Three main themes emerged from the interview data with associated subthemes, which are expanded upon below.

Theme One: Support may be Provided by Being Flexible and Adaptive

The results indicate that supporting students on rural clinical placements requires flexible and adaptable approaches to accommodate effective clinical learning in the context of rural-specific factors. This is captured by the two subthemes below.

Sub-theme: Flexibility of team structure

Persistent challenges associated with staffing shortages in rural health services described by clinical educators meant that flexibility was key in managing both the student learning experience and effective use of available staff resources. Commonly only one student was allocated to a single discipline at a time, and this student was consequently supervised by multiple clinicians from both the immediate clinical discipline and the wider multidisciplinary team. Supervision of students also necessitated quick adjustments to suit changing workplace situations. For example, one speech pathology educator voiced that they were the "primary supervisor for speech and OT, but they [*student*] got external OT supervision for clinical components" (CE11).

> We obviously have a smaller team. So, there may be days where we've had quite a significant amount of unplanned leave in the department and then it's quite hard to navigate where the student will go … we might have to put them with the assistants for a day if we don't have staff. (CE7)

> We can't always guarantee that the types of clients we have are suitable for students. That tends to vary a bit. And with inpatients we can either be absolute flat out, and we need to divert extra outpatient resources to inpatient, or we can have absolutely no one in there at all. That's one reason we take only the four students a year and just one at a time so that we know there will be enough work for the student. (CE5)

Whilst flexibility was considered essential to ensuring students were integrated into rural health services in a sustainable way, this strategy was discussed as having variable impacts upon the students' learning. Juggling the supervision of a student between multiple clinicians was noted to impact the continuity of supervision provided. When staff shortages occurred, clinical educators reported that increased workload demands limited their ability to prioritize student learning opportunities.

> The challenges with rural are that staffing can be an issue. Often the priority can shift to just making sure we are covering the caseload. As a result, I think that students sometimes do not get the supervision that they require, or their needs are prioritized as slightly lower. (CE2)

Being the sole student was described as leading to a perceived increased intensity of observation where "all eyes are on you" (S3) with respect to assessment of performance. Limitations were also identified with professional isolation in solo placements, where students faced reduced or no ability to benefit from peer interaction or support.

> Sometimes that ability then to debrief, especially if they're here by themselves, they don't have another peer… there might not even be another student of another professional here at the same time. Finding that time then to debrief… has been probably quite challenging. (CE6)

> It's just me here. And that's the only thing like, I feel a little bit alone. (S10)

There was also discussion from both clinical educators and allied health students that flexible rural placement structure provided many positive educational opportunities, which allowed students to develop increased autonomy, be immersed authentically within a clinical team, and benefit from the experience and support of multiple individuals.

> I'm the only physio student there and I have two educators ... in the city there was usually at least a two to three student to one educator ratio, and ... they might not have had the time to go in as much depth with cases … a lot of my questions have been answered in a much more comprehensive way rurally. (S9)

Sub-theme: Adjusting support to the need of the student

Clinical educators reflected on the need to adjust their supports to target students' clinical performance and overall wellbeing to reflect the unique challenges of rural placements, including the generalist rural caseload and psychosocial factors (such as limited access to town services and geographical isolation from support networks). This was typically described as a highly individualized and sometimes formal process, dependent on the need to clarify aspects of rural life and work based on each student's prior experience.

> We normally ask the student to fill out a little questionnaire before they come to us. That just gives us a bit of background on what placements they've done, what they find are triggers for their stress … any other background stuff like that. (CE3)

Understanding a students' prior clinical and personal experiences was critical in successfully adjusting rural placement supports. Both students and educators recognized the different levels of preparedness and thus varying support needs for those who had previously lived or worked in rural settings. For some students there was a sense of making the most of what they knew, which they felt gave them an advantage. Educators also reflected this idea by recognizing that those from rural backgrounds were better able to embrace the challenges and uniqueness of rural life. This transition was viewed as being smoother for students who had previous experience living rurally. "The couple of students I've had so far this year, they come from a rural setting - so they understand a lot more … the challenge would be for people that come in from the city" (CE1).

Conversely, extra support was considered essential to ensure success on rural placement for students with reduced experience of being geographically isolated from known supports, reduced exposure to rural living, and/or reduced transferable clinical experiences (such as experience gained on previous placements).

> Definitely they need a bit more support when they haven't lived out of home before, or if they have never ever been anywhere rural or remote before. So that might be a bit more support in terms of culture shock, or just navigating things that they're not used to at the moment. So, shops not open on a Sunday or weather, heat, animals ... those kinds of things. (CE11)

> We get a lot from [*other regional location*] so I suppose the culture shock isn't as big a deal. The ones that do come from [*metropolitan location*], there is definitely more that culture shock that they're trying to adjust to and also develop their clinical skills. (CE10)

> They're less stressed if it's not their first placement… and then they've got a better chance of translating those skills across and not having to just learn everything. (CE3)

Theme Two: Support may be Provided Bespoke to Rural Practice

Subtheme: Diversity on top of complexity

Clinical practice in a rural setting was acknowledged by all participants to be diverse in scope, requiring clinicians to constantly traverse their full scope of practice, across the continuum of care (i.e., acute, outpatient, community, primary care, outreach), and across the lifespan. This was perceived to be a challenge for students who only had previous experiences of clinical placements in a specific setting.

> Being adaptable definitely has to be the number one skill. As opposed to going on a cardio placement or neuro where you just see one or the other … you're seeing a whole heap of patients from completely different backgrounds, with really, really complex presentations. (S6)

> It can be quite overwhelming when we send out our initial email to them [*students*] saying, 'It's a rural generalist position, you're going to cover pretty much paediatrics to residential aged care'. Each day can be different, and it's hard to prep for. (CE3)

Additionally, rural practice was seen to require allied health students to navigate complex clinical presentations that may be managed by more specialist services if they were in an urban setting. This was seen by some students as an impetus for learning.

> There might not be that support system available on site for you … we might not be able to escalate those things as you would in a metropolitan area. So, if you get this great tricky question, you can't really ask another person for the answer - because you're the person who's supposed

> to know the answer. It's just being more independent, learning a lot more on your feet and being able to adapt more. (CE7)

> In the [*metropolitan region*], people are more accessible. You've got all those people to talk to 24/7. But here … I feel like it's just a lot trickier here. And that kind of prevents how much you can do as well, in terms of referring. (S11)

Given the diversity and complexity of the rural caseload, some clinical educators and students adopted the approach to learning on clinical placement, where instead of selecting 'student appropriate cases', allied health students would engage with a range of clients and would share the management of the patient with their clinical educators. Supporting students to manage the diversity and complexity of the rural caseload using this approach was perceived to be beneficial. "If a client comes in and is really complex, and I'm just sitting there like a goldfish, she'll come in and help out and then give the client back to me or keep going" (S4).

Subtheme: An expectation-reality gap

All participants acknowledged that there was often an expectation-reality gap in relation to allied health students' expectations, and their experiences of the challenges of diversity, complexity, and workload volume. These challenges sometimes placed allied health students in a 'sink or swim' situation, where they were expected to manage appropriately.

> We arrived to like 350-person-plus outpatient waitlist - that's huge. So it was nuts. And in a physio department of one, like there's just no way. It's ridiculous. So, we got there and was pretty well thrown in the deep end. (S8)

Given the challenges of diversity of caseload, some students felt overwhelmed with rural generalist practice. This supports the belief, conveyed by both students and clinical educators, that rural generalist clinical placements are much too broad to be prepared for in every aspect, and students are not to be expected to be prepared for everything. "Essentially, out here you would call it more of a rural generalist … as a student, it's very eye opening and sometimes it can feel like 'how am I supposed to know everything'" (CE9).

Subtheme: Culture of the rural patient cohort

Students felt an additional challenge was adapting their care to the unique rural culture and needs of those living in rural settings. For example, students required support to respond to the challenges associated with weather complications, agricultural occupations, access to healthcare, and belief systems associated with stoicism that were seen as unique to those living in rural settings.

> Definitely more of a need for really, really good patient education rurally. Some people living rurally don't have access as readily to healthcare … they might not get reviewed as frequently as someone in metro. So, in terms of depth of education and quality, I think it does need to be really spot on. (S9)

> The nature of the placement being that we are in a remote location, it kind of automatically makes every single client complex … having to consider context and social dynamics and social determinants of health and all those sorts of things, cultural ... everything. And I'd say definitely adjusting to learning about what trauma is, and then trauma-informed practice has been a big area that I've been working on with the students that come through here. (CE11)

The challenges around adapting care to those living in rural settings became obvious when students were undertaking discharge planning for patients returning to a myriad of community settings that ranged in complexity.

> The actual transport of getting these people home was something obviously that I'd never had before. Most people in [*metropolitan region*] have a family member who comes to pick them up, or they get the train, or something close. But there are people who were so far away. (S7)

Theme Three: Support may be Provided Within a Culture of Teamwork

Subtheme: The transitional relationship

There was a strong perception amongst all participants that the relationship between students and clinical educators was more focused on collegial mentorship compared to their clinical placement experiences within urban settings. Factors that contributed to this included responding to the psychosocial support needs of students as they transitioned to the rural setting and the pragmatic and community aspects of rural practice. "I think the biggest obstacle for me, and the biggest hurdle is really the transportation thing… Not having a car.… my team member just dropped me off [*this afternoon*]" (S10.)

> No one warned me that that would be a part of the role … it's a hard relationship because you are sort of remote, but you're meant to be their educator? ... She also got sick and then I wanted to drop her off like a little food package, and then I was like, 'I don't know if that's appropriate'. So I didn't …. she didn't have COVID but it's the times - if you've got a cold you have to stay inside basically. So, if they don't have anyone else around it's quite challenging. (CE4)

This collegial mentorship also extended to social activities where clinical educators actively involved students in the community.

> We have a lot of young clinicians in their 20s and 30s, who just take them [*students*] under their wing, and they invite them to every single thing that they would do … going to the races here, they'll be going to the balls around the place, they'll go out to trivia night on Tuesday night with the rest of the team. Everybody makes quite a concerted effort to involve them [*students*] socially in the town, to show them the benefits of living rurally. (CE5)

The sense of the rural clinical educator being a colleague and mentor was further reinforced by the clinical educators' experiences of recruiting staff members who had previously attended the location as a student.

> One thing that's probably surprised me working here is how many students come back and want to work for us. I think we've got about four or five staff members who did placement out here, and they just loved it so much that they followed up and are now working in our team. So I think that placement can really have a positive impact. (CE8)

> If we want people to come and work here, it's not just about showing them it's a good workplace, it's about showing them that it's a good lifestyle … At the moment, we have two new grads working here, both of whom were students last year, one in OT … and one here who was a dietetic student last year. (CE5)

Subtheme: Support from the interprofessional team

Students and clinical educators reflected on ways in which the interprofessional team supported allied health students' clinical placements in rural settings. Working in smaller teams enabled students to engage with professions other than their own, supporting their interprofessional and collaborative practice development. "There's a camaraderie that's not so prevalent in [*metropolitan*] that I've seen… it's been nice getting to work in such a close team and with people that are from different professions" (S9).

> I love that everyone's got each other's backs, and the team is fantastic. The team leader is an OT who is just like, gunshot - just so great. The team works so well together, and everyone's always chatting, and it's just a great dynamic. (S1)

Additional to receiving support from other professions, both students and clinical educators reflected on the strong team culture present in rural practice. This culture was perceived to be a willingness from all members of the team to assist others in their learning and was considered a support network for allied health students who may experience challenges during their rural clinical placement. "If I got stuck with doing something, I feel like I could ask anyone - any worker, whether it be a nurse or dietitian" (S2).

Amongst the participants, environmental factors were also considered to contribute to a culture of interprofessional teamwork, with the main enabling factor being shared accommodation. The opportunity to live alongside allied health students from other professions enabled peer support during clinical learning, interprofessional learning opportunities, and social opportunities.

> We had such an awesome group there. There were so many other students … all different disciplines. And with everyone being thrown into that same very unfamiliar setting with no support networks, we all bonded together really really quickly. (S8)

> I've made some good friends in the accommodation - everyone's really lovely. I was a bit hesitant … will I be able to find the right people and make friends? But there's a big group of health professionals, there's a big group of students. (S4)

> If they don't [*have local accommodation*], they have accommodation in our nurses' quarters. Our nurses quarters sits directly above the Allied Health team, we are in the same building… We might have a physio student and OT student, and a speech student all here at this time. So, they've automatically got that inbuilt support network in the students there. (CE5)

DISCUSSION

This study explored the support needs for allied health students during clinical placement in rural Australia. The perspectives of both students and clinical educators highlighted the importance of implementing adaptable and flexible solutions in response to the unique challenges experienced on rural placement. These findings are largely consistent with the growing body of literature describing factors that contribute to positive rural placement experiences, including adequate support from universities and clinical educators, sufficient diversity of learning experiences, immersion in rural life, preparation for logistical aspects of placement, and positive social and professional interactions with peers (Fatima et al., 2018; Smith et al., 2018; Sutton et al., 2016; Walker & Forbes, 2022; Wolfgang et al., 2019). Key aspects of the results are discussed below.

Overcoming the Inevitable Rural Resourcing Dilemma

Participants from this study suggested flexible solutions to support successful and sustainable student learning within the resourcing constraints of rural health services. Challenges with resourcing in rural health services are well understood, including the impact this has on health professionals (Sutton et al., 2016). Stress in health professional staff has been linked to staff shortages and resultant increased workload levels (Maloney et al., 2013), which is further exacerbated by the additional responsibility of educating students (Astill et al., 2020; Marlow & Mather, 2017). High stress levels in clinical educators or supervisors have also been identified as an impediment to provision of positive rural placements for students (Maloney et al., 2013). It is therefore understandable that clinical educator participants from the present study placed importance on minimizing impacts of resourcing limitations and the subsequent challenges this presents when supervising students.

Participants in this study prioritized flexibility and adaptability in the face of limited resources, discussing the importance of introducing the student into this culture of flexibility so that this was both normalized and capitalized upon to create novel learning opportunities. Students were supervised by different clinicians, joined with other discipline teams, participated in outreach services, engaged with auxiliary learning activities to fill downtime (e.g. developing resources or in-services), and were encouraged towards independence with service delivery across the duration of their placement. The strategies identified in the current study are supported by previous research, which demonstrated that when the capability of allied health students increases, the level of supervision reduces - which enables clinical educators to redirect how they spend their time with students (Hudson et al., 2012; Hughes & Desbrow, 2010).

Scaffolding for Success: Understanding Learning Within a Rural Setting

Providing learning experiences and clinical education that was individualized to each student with respect to their stage of learning and learning needs, was deemed especially relevant in rural clinical education. This was framed in the context of a rural generalist caseload, which presented different challenges for students at different points in their learning journey. Students with prior experience of being geographically isolated from known supports, previous exposure to rural living, or existing transferable clinical experience (e.g., those gained on previous placements) were perceived as better prepared to engage on rural placement in context of rural-specific challenges, such as a generalist caseload and resourcing limitations. Conversely, students who did not have relevant experience were perceived to require additional support to optimally engage with, and benefit from, rural placement. This was especially true from the perspective of clinical educators, who felt that prior placements allowed students the opportunity to develop transferable clinical skills, without the presence of the extra challenges unique to rural placement. Thus, there is likely a benefit to ensuring placement learning is scaffolded with sufficient support and guidance for students to achieve success and promote positive placement experiences in the context of their existing experience and skill levels (Verenikina, 2008).

It Takes a Community to Raise a Student: Using Support from the Healthcare Team Wisely

The findings of the current study have emphasized the interprofessional nature of the support and experiences that are provided to allied health students on rural placements. The rural clinical learning and practice environments in this study were viewed as highly collaborative, where students were

actively encouraged to engage with other students and health professionals from the same and different disciplines (Cragg et al., 2010; Gum et al., 2013). Similar to previous research, health students value interprofessional collaboration and interactions on rural placements (Bradley et al., 2020; Smith et al., 2018), and the positive influence of a friendly, collegial, and collaborative environment has been significant enough to outweigh or counteract barriers experienced by students, such as financial impact, travel, or accommodation difficulties (Bradley et al., 2020). Furthermore, opportunities for students to shadow with other members of the multidisciplinary team gave students in this study a broader perspective of healthcare and insight into the professional roles that contribute to meeting the varying needs and preferences of patients (Kusnoor & Stelljes, 2016). Despite the benefits, challenges may arise with respect to navigating inconsistencies between the different mentors and educators whom a student may be allocated to, for example differing educator expectations, teaching styles and feedback (Farrow et al., 2000). Explicit structuring of this 'multiple mentor' approach to supervision can assist with mitigating these difficulties (Copley & Nelson, 2012), and might involve coordination of feedback, role clarification amongst supervisors and equitable rotation amongst team members. These strategies would likely be appropriate to consider on rural placement to enhance the placement experience.

Extended Roles of Clinical Educators: Where is the Line Between Educator, Colleague, and Friend?

Clinical educators described the necessity of providing support to rural students in domains outside of clinical learning, and thus the concept of a 'transitional' relationship emerged, where educators may take on a broader role in supporting a student's emotional, social, and physical wellbeing in context of factors unique to rural placements (e.g., displacement from support networks and personal resources, unfamiliarity with rurality that impacts physical or psychosocial safety). This notion of a 'transitional relationship' was echoed by students, who emphasized how much they appreciated accessing support and a sense of understanding from their educators around factors outside of clinical learning (e.g., social isolation, homesickness, and logistical limitations). Educators in the current study noted that navigating this extended role was often challenging, with indistinct boundaries causing confusion around how to implement the appropriate but necessary supports for rural students. Similar experiences of 'role conflict' or 'role confusion' within the student-supervisor relationship have been reported widely in health professional literature (Bray & Nettleton, 2007; Meeuwissen et al., 2019). Additional to the challenge of 'role conflict', the findings of the current study have identified the intersectional complexity of providing unique support to each student and achieving this in the context of resourcing constraints. Accordingly, the current study suggests that the provision of clear expectations and guidelines around the 'transitional relationship' in a rural context may benefit both educators and students, and may promote positive placement experiences.

LIMITATIONS

Whilst efforts were made to ensure the transparency and reflexivity of the study, there are limitations that must be acknowledged. Efforts were made to capture data from a range of individuals, however the huge diversity of professions considered as 'allied health' were not fully represented within the sample. Majority of the participant sample are students and clinical educators from the physiotherapy discipline, which is a further limitation. Whilst many countries report similar difficulties with provision of allied health services and student practice experiences in regional and rural areas, transferability of these results to regions outside of Australia and to other professions may be limited.

CONCLUSION

Rural allied health placements necessitate unique strategies to support student learning within the context of sustainable practices for rural health services, to ensure positive placement experiences for both students and clinical educators. Clinical educators and students agreed on the need for more individualized student support systems, sufficient diversity of supported learning experiences, and immersion in all facets of rural life.

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About the Journal

The International Journal of Work-Integrated Learning (IJWIL) publishes double-blind peer-reviewed original research and topical issues related to Work-Integrated Learning (WIL). IJWIL first published in 2000 under the name of Asia-Pacific Journal of Cooperative Education (APJCE).

In this Journal, WIL is defined as:

> *An educational approach involving three parties – the student, educational institution, and an external stakeholder – consisting of authentic work-focused experiences as an intentional component of the curriculum. Students learn through active engagement in purposeful work tasks, which enable the integration of theory with meaningful practice that is relevant to the students' discipline of study and/or professional development* (Zegwaard et al., 2023, p. 38*).

Examples of practice include off-campus workplace immersion activities such as work placements, internships, practicum, service learning, and cooperative education (co-op), and on-campus activities such as work-related projects/competitions, entrepreneurships, student-led enterprise, student consultancies, etc. WIL is related to, and overlaps with, the fields of experiential learning, work-based learning, and vocational education and training.

The Journal's aim is to enable specialists working in WIL to disseminate research findings and share knowledge to the benefit of institutions, students, WIL practitioners, curricular designers, and researchers. The Journal encourages quality research and explorative critical discussion that leads to the advancement of quality practices, development of further understanding of WIL, and promote further research.

The Journal is financially supported by the Work-Integrated Learning New Zealand (WILNZ; www.wilnz.nz), and the University of Waikato, New Zealand.

Types of Manuscripts Sought by the Journal

Types of manuscripts sought by IJWIL is primarily in two forms: 1) *research publications* describing research into aspects of work-integrated learning and, 2) *topical discussion* articles that review relevant literature and provide critical explorative discussion around a topical issue. The journal will, on occasions, consider good practice submissions.

Research publications should contain; an introduction that describes relevant literature and sets the context of the inquiry. A detailed description and justification for the methodology employed. A description of the research findings - tabulated as appropriate, a discussion of the importance of the findings including their significance to current established literature, implications for practitioners and researchers, whilst remaining mindful of the limitations of the data, and a conclusion preferably including suggestions for further research.

Topical discussion articles should contain a clear statement of the topic or issue under discussion, reference to relevant literature, critical and scholarly discussion on the importance of the issues, critical insights to how to advance the issue further, and implications for other researchers and practitioners.

Good practice and program description papers. On occasions, the Journal seeks manuscripts describing a practice of WIL as an example of good practice, however, only if it presents a particularly unique or innovative practice or it was situated in an unusual context. There must be a clear contribution of new knowledge to the established literature. Manuscripts describing what is essentially 'typical', 'common' or 'known' practices will be encouraged to rewrite the focus of the manuscript to a significant educational issue or will be encouraged to publish their work via another avenue that seeks such content.

By negotiation with the Editor-in-Chief, the Journal also accepts a small number of *Book Reviews* of relevant and recently published books.

Reference
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