BUILDING CAREER PATHWAYS IN THE ALLIED HEALTH INDUSTRY: A PRACTICAL FRAMEWORK

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ABSTRACT: ***U****nderstanding and application of work skill requirements and the pathways to develop those skills from novice to advanced practitioner are fundamental to success in any given health profession. The research reported in this paper aims to guide the progression of allied health professionals in achieving this objective. Currently work placements in allied health disciplines provide an introduction to integrating clinical skills in the workplace; however they do not necessarily consider adaptability and sensitivity to the workplace environment or an awareness of fundamental employability skills required for career progression. In addition, current workplace assessment in the allied health industry is confined to professional appraisal/development more so than supporting the individual's capacity to progress their career. The Allied Health Career Development framework [AHCD] developed through this research is a practical tool to guide, monitor and foster progress of the individual from novice to advanced practitioner via the delineated levels of autonomy embedded within it. These levels of autonomy are ascribed to six workplace skill attributes - initiative & goal orientation; technology & resource use; learning & reflecting; planning & leadership; problem solving & critical thinking; and, communication & professionalism. The AHCD outlines the attributes required in each of these facets to progress from novice to advanced practitioner. The value of the research lies firstly, in monitoring professional growth; secondly, in the use of reflective practice and peer/mentor coaching, and thirdly, in creating a more confident, satisfied and goal orientated employee in the allied health workforce.*

[**KEY WORDS:** *Professional Career Development, Allied Health, Reflective Practice, Emotional intelligence, Work Skills]*

INTRODUCTION

Careers may be the 'property' of individuals and yet for the employed, it will be planned and managed by the organisations (Baruch, 2003, p.59). However, life-long learning and professional career development remains the ultimate responsibility of the individual. New graduates in addition to coping with a constantly changing world, are faced with further uncertainty and challenges of transferring their skills, knowledge and practice to the professional environment. Career development learning is therefore an indispensable tool for sustained graduate employability (Smith et al., 2009).

The need to validate professional development and its impact on an individual's career/profession increases pressure on an individual to become competent reflective practitioners. Reflection is a critical part of

learning from experience and is important in developing and maintaining competence across professional careers. Internationally, health professionals are required to provide evidence of continual professional education and reflective practice as part of their professional registration and licensing processes (Gotlib et al., 2012; Australian Physiotherapy Council, 2011; Speech Pathology, Australia, 2011). A health professional is guided to develop their abilities in areas such as knowledge based attributes, clinical skills, evidence based practice, communication (Lindquist et al., 2006; Turner et al., 1997; Dalton et al., 2012) transferable skills (Jones et al., 2010) and critical reflection (Paterson & Chapman, 2013). However, possessing these generic skills and knowledge alone does not guarantee competence in the workforce nor successful career development.

As Jones et al., (2010) posits there is a general lack of information regarding the successful transition of the professional within the workplace. This anomaly however, can be addressed with time through self-directed and experiential learning, guided reflective practice, and focused mentoring and feedback. In this context, the Allied Health Career Development framework (AHCD) proposed in this research, is designed to incorporate core work skill competencies together with emotional and social skills (Emotional Intelligence) and reflect on levels of autonomy within the workplace to facilitate career progression.

The aim of this study is therefore to deliver an applied tool to facilitate the successful transition of a health professional from novice to advanced practitioner while focusing on key competencies and levels of autonomy through reflective practice and emotional and social sensitivity (Emotional Intelligence) to the workplace.

THE FRAMEWORK IN CONTEXT

The Allied Health Career Development framework (AHCD) is a competency framework which provides a means of benchmarking one's professional capacity within specified levels of autonomy (Refer Table 1).

Table 1 : Allied Health Career Development Framework [AHCD]

Facets of Competency	Affective Domain	Levels of Autonomy				
		Prescribed Direction Level 1 *Highly structured directions and modelling from supervisor/mentor*	**Bounded Direction Level 2** *Boundaries set by and limited directions from supervisor/mentor*	**Scaffolded Direction Level 3** *Scaffolds placed by supervisor/mentor*	**Self-Motivated Direction Level 4** *Individual initiates and supervisor/mentor provides guidance*	**Open Direction Level 5** *Individual operates within self-determined guidelines*
A. Initiative & Goal Orientation **Harmonises** professional role within scope of practice and **determines** goals including skills and knowledge	*Self-Actualisation*	High degree of guidance to identify and adapt to professional role and to achieve established outcomes	Identifies with professional role requirements with some degree of guidance to achieve outcomes	Establishes professional role independently and adapts to situations with minimal guidance to achieve outcomes	Identifies and adapts to professional role in a variety of contexts. Demonstrates initiative and self-directed outcomes to meet potential	Highly developed sense of responsibility and autonomy in professional context to exceed potential
B. Technology & Resource Use **Finds** and **generates** information to identify evidence basis for practice	*Adaptability*	Uses basic techniques, approaches and equipment with a high degree of guidance to find evidence based practice	Sensitive to change and uses techniques, approaches and equipment with some degree of guidance to apply evidence based practice	Receptive to change and uses techniques, approaches and equipment independently to extend evidence based practice	Responds to change and uses a combination of strategies to critically evaluate evidence based practice	Embraces change and uses best available evidence and different delivery strategies to contribute and add value to evidence based practice
C. Learning & Reflecting **Focuses** and **validates** lifelong learning skills for continual professional development	*Self-Efficacy*	High degree of guidance to reflect and evaluate practices to establish lifelong learning skills and professional development	Some degree of guidance to reflect on learning skills and engage in professional development requirements	Critically evaluates the match between theory and practice to extend lifelong learning skills	Critically evaluates professional development to generate and share knowledge, resources and information	Uses experience and expertise to self-direct learning and engage in a process of continual reflection and evaluation
D. Planning & Leadership **Prioritises** tasks and regulates time and resources to **manage** self and teams to achieve goals	*Self-Management*	Organises, plans and schedules tasks with a high degree of guidance	Develops prescribed goals and articulates own ideas and visions with some guidance	Develops self-determined processes with minimal assistance to set further learning goals	Evaluates information to independently develop and self-monitor priorities and manage learning goals	Articulates personal visions, goals and innovative strategies, and gives direction and guidance to teams
E. Problem Solving & Critical Thinking **Analyses** and **synthesises** to devise solutions and generate new knowledge	*Discernment*	High degree of guidance to apply existing knowledge and skills to identify and understand problems	Moderate degree of guidance to apply existing knowledge and skills to understand problems and establish a focused solution	Limited guidance to connect knowledge and skills to solve problems through in-depth analysis	Independently connects knowledge and skills to insightfully solve unfamiliar and abstract problems	Uses deep holistic reasoning to fill self-identified gaps and extrapolate quality outcomes
F. Communication & Professionalism **Sensitivity** in interpersonal communication and multidisciplinary team work to process, understand and respond while **respecting** ethical, social and cultural (ESC) issues	*Empathy*	Highly structured guidance to work within a multidisciplinary team, and in communicating knowledge. Practice is informed by cultural awareness training.	Some degree of guidance to exchange information, understand perspectives and contribute within a multidisciplinary team. Develops cultural sensitivity into practice.	Demonstrates confidence and assertiveness in communicating within a multidisciplinary team. Embodies a practice which is culturally safe.	Demonstrates knowledge and understanding from several perspectives and effectively communicates with a diversity of individuals in a culturally competent manner.	Negotiates and asserts values while respecting the contribution of others in communicating information. Seamlessly incorporates cultural ease into practice.

The objective in this framework is to integrate generic professional competencies with levels of autonomy in the Allied Health industry to assist professionals in their career development. The concept was developed by A Kimmerly, BPhy, UQ., MPhty. Flinders University and S Bandaranaike, James Cook University. It is based on the Work Skills Development Framework of Bandaranaike & Willison [2009, 2014].

The basic concepts in this framework are defined as follows:

- **Competencies -** Generic work skills required in the professional practice of allied health occupations. They are a set of behaviours that provide a structured guidance to engage in core allied health proficiencies.

- **Affective Domain [Emotional Intelligence] –** A new concept introduced perceptibly for the first time, to a professional career development framework. The affective domain was originally developed by Bloom *(*Krathwohl *et al.,* 1973*)* and later developed by others (Mayer & Salovey, 1993; Goleman, 1998) to incorporate Emotional Intelligence (EI). EI is a form of emotional and social intelligence that involves the capability of recognising and regulating emotions in one self and others (Goleman, 2000), understanding others' feeling, recognising and using it to influence others (Bar-On, 2006; Goleman, 1995; Salovey & Mayer, 1990) and improving oneself through self-management (Goleman, 1998) to influence career achievement (Goleman, 1995). It has been noted that people with a high level of EI experience have more career success, build stronger personal relationship and lead more effectively (Cherniss & Goleman (2001).

- **Autonomy** – A designated level of direction within which a practitioner can progress from a Prescribed Direction (Level 1) to an Open Direction (Level 5) and determined by one's willingness to work to a specified level.

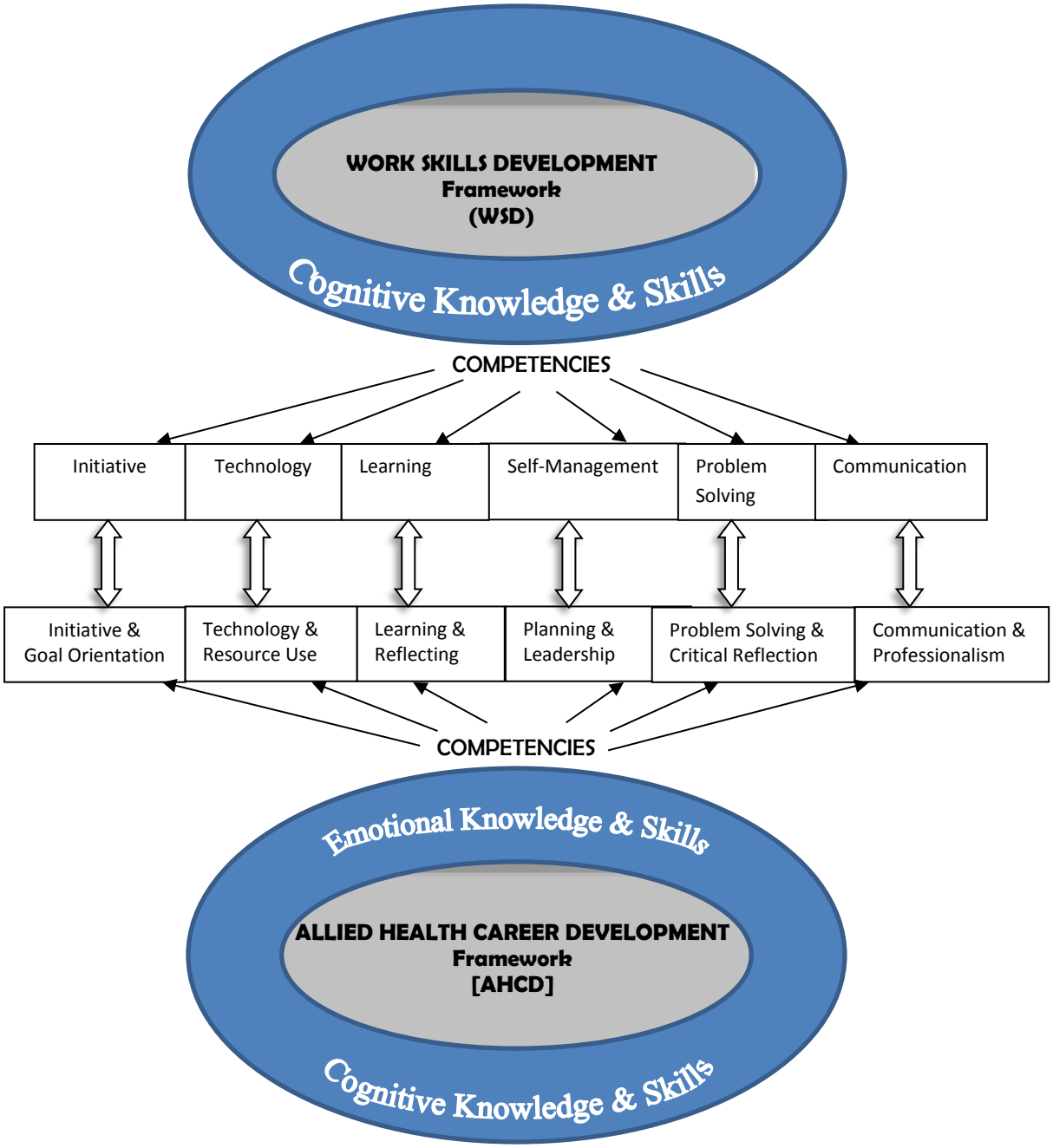
Background to the Framework

The AHCD is based on the *Work Skills Development framework* (WSD) (Bandaranaike & Willison, 2009, 2010), a generic framework used by placement students to reflect on key employability facets and their level of autonomy in the workplace, pre and post placement. The WSD framework was designed using a combination of graduate attributes (Graduate Attributes, 2009), employability skills (DEST, 2002, 2006) and Bloom's taxonomy (Bloom et al., 1956).

As illustrated in Figure 1, the WSD exemplary is used in structuring the AHCD. The AHCD in addition incorporates allied health professional standards, discipline specific competencies of relevant professional boards, and competencies considered for specific areas of practice (PBA, 2010; WFOT, 2008; PSA, 2010).

A highlight of the AHCD is the inclusion of the affective domain (Emotional Intelligence) as an associated concept.

Figure 1: Linking Work Skills Development framework [WSD] with Allied Health Career Development framework [AHCD]



The Allied Health Career Development framework (AHCD) is a three dimensional framework that focuses on:

i. Six **Facets of Competency** – *Initiative & Goal Orientation*; *Technology & Resource Use; (Lifelong)Learning & Reflecting; Planning and Leadership, Problem Solving & Critical Thinking; Communication & Professionalism,*
ii. An associated **Affective Domain** - *Self-Actualization, Adaptability, Self-Efficacy, Self-Management, Discernment, and Empathy* for each of the competencies, thus highlighting the significance of emotional intelligence in the practice of allied health,
iii. Five delineated **Levels of Autonomy** – *Prescribed Direction; Bounded Direction; Scaffolded Direction; Self Motivated Direction; Open Direction* to guide the transition of a professional from novice to advanced practitioner

APPLICATION OF THE FRAMEWORK

i. Facets of Competency

The characteristic of a holistic professional is described in terms of knowledge and skills that build the foundations of lifelong learning, including critical, analytical, problem solving and communication skills, and the ability to deal with change and diversity (Australian Government, 2013). The AHCD is designed to guide professionals in the workforce to achieve their desired career pathways (professional development) by reflecting on the core competencies and associated features given below.

A. Initiative & Goal Orientation– seeks personal growth through reflection and active involvement; initiates, clarifies and establishes the specific role and shows high motivation to engage.

B. Technology & Resource Use - adapts to evidence based practice by finding and generating appropriate information.

C. Learning & Reflecting - demonstrates self-efficacy by focusing and validating lifelong learning skills; reflects and evaluates; projects goals and visions.

D. Planning and Leadership - validates intra-personal skills of self-management and inter-personal skills of social awareness in providing guidance and direction to self and others.

E. Problem Solving & Critical Thinking - discernment in decision making, clinical reasoning and problem solving with positive outcomes.

F. Communication & Professionalism - projects sensitivity to ethical, social and cultural issues in interpersonal communication and teamwork.

ii. Affective Domain

Table 2: Application of Cell Descriptors to Health Professionals in Terms of the Affective and Generic Competencies

FACET	AFFECTIVE APPLICATION	GENERIC APPLICATION : Example
A. Initiative & Goal Orientation **Harmonises** professional role within scope of practice and **determines** goals including skills and knowledge	SELF-ACTUALISATION Health professional determines their potential and works towards achieving it through application, development and mastery of skills and knowledge within their chosen scope of practice	- Establishes outcomes in line with job description form (JDF) or equivalent role descriptor which outlines the expectations of the position - Operates within scope of practice as outline by JDF/role descriptor and relevant national Boards' code of conduct. - Goals are orientated towards long term direction
B. Technology & Resource Use **Finds** and **generates** information to identify evidence basis for practice	ADAPTABILITY Health professional is receptive to situations of change and is actively persuaded by evidence to respond to a dynamic environment	- Incorporates multimedia such as video conferencing, webinars and on-line education to inform practice - Incorporates resources such as telehealth to provide clinical practice
C. Learning & Reflecting **Focuses** and **validates** lifelong learning skills for continual professional development	SELF-EFFICACY Health professionals belief in their ability to achieve their goals which is influenced by experience, behaviour and feedback	-Upholds registration standards in line with the relevant national Boards to ensure practice standards are maintained and competence is continually improved within the chosen scope of practice
D. Planning & Leadership **Prioritises** tasks and regulates time and resources to **manage** self and teams to achieve goals	SELF-MANAGEMENT Health professionals ability to maximise their efficiency through emotional self-control, transparency, adaptability, initiative and optimism	- Tasks include but are not limited to client contact, administrative duties and multidisciplinary contact and liaison - Management and planning is for short /long term goals
E. Problem Solving & Critical Thinking **Analyses** and **synthesises** to devise solutions and generate new knowledge	DISCERNMENT Senses others emotions to understand their perspective and take an active interest in their concerns	- Applies clinical reasoning to synthesis and analyses clinical situations - Utilises available resources, technologies and personnel to inform practice
F. Communication & Professionalism **Sensitivity** in interpersonal communication and multidisciplinary team work to process, understand and respond while **respecting** ethical, social and cultural (ESC) issues	EMPATHY Health professional uses professional judgment and insight to determine a rational outcome	- Utilises skills to communicate and interact with clients, health professionals and other personnel involved in the clients care - Although cultural definitions provide some reference to Indigenous culture, attributes can be applied across a multicultural population

Sources: Kreitner, R. & Kinicki, A. 2010, Harris, M.G. & Associates 2006,

As illustrated in Table 1 and Table 2 (above), each AHCD competency has an associated EI construct. Yet, all six EI constructs are interchangeable and should not be locked into water tight compartments in applying the framework. The individual EI associations with each competency assist the practitioner to focus and build a relationship between the two concepts. The main EI competencies of self-awareness, self-management, social awareness and relationship management identified by Salovey & Mayer (1990) and Goleman (1995) should also be applied in its entirety to develop the affective domain in total.

The ability to perceive, use, understand and manage emotions (Mayer & Salovey, 1997; Mayer, Salovey, & Caruso, 2004) is emerging as an important concept in the allied health employment sector, and EI is now a core competency for health care administrators (Freshman & Rubino, 2002). EI constructs play a key role and therefore its integration in the AHCD and in an allied health context is most relevant. This close association between the generic application and the affective (EI) application for each of the six competencies is illustrated in Table 2.

iii. Levels of Autonomy

The ascribed levels of autonomy incorporated within AHCD are indicative of potential growth of a practitioner from level 1 to level 5. These levels of autonomy provide opportunities to make choices and reflect on individual performances and career direction. They guide the individual in the choice of new skills and contribute to confidence building and greater accountability and responsibility. Such a progression is illustrated for the competency, *Communication and Professionalism* in Table 3 below.

In practice it must be noted that Level 1 can be the entry point for a new graduate or someone who has graduated for example, 5 years ago and been out of the workforce. An individual can reach different levels of autonomy in each of the competencies at any given moment. Further, the timing in achieving individual levels of autonomy cannot be predicted and will vary from one person to another depending on multiple factors such as passion, drive, type of work/organisation, mentor facilities, work conditions, opportunities available, networking facilities and, political or economic intervention. In some competencies it may be possible to move within a year from Level 1 to 3 and in other competencies it may take 10 or more years to move from Level 1 to 5.

The three components of the AHCD framework - Competencies, Affective Domain and Levels of Autonomy, are complementary and facilitate self-directed learning and reflective practice which ultimately promote professional development.

Table 3: Sample Cell Descriptors and Levels of Autonomy for Communication & Professionalism [Facet F]

Level of Autonomy	Level status	Communication & Professionalism
LEVEL 1: Prescribed Direction	*Highly structured directions and modelling from supervisor/mentor*	Exceedingly dependent on guidance to work within a multidisciplinary team, and in communicating knowledge. Practice is informed by cultural awareness training.
LEVEL 2: Bounded Direction	*Boundaries set by and limited directions from supervisor/mentor*	Some degree of guidance to exchange information, understand perspectives and contribute within a multidisciplinary team. Develops cultural sensitivity into practice
LEVEL 3: Scaffolded Direction	*Scaffolds placed by supervisor/mentor*	Demonstrates confidence and assertiveness in communicating within a multidisciplinary team. Embodies a practice which is culturally safe.
LEVEL 4: Self-Motivated Direction	*Individual initiates and supervisor/mentor provides guidance*	Demonstrates knowledge and understanding from several perspectives and effectively communicates with a diversity of individuals in a culturally competent manner.
LEVEL 5: Open Direction	*Individual operates within self-determined guidelines*	Negotiates and asserts values while respecting the contribution of others in communicating information. Seamlessly incorporates cultural ease into practice.

The Transition – A Case Study

The following case study illustrates a common narrative in transitioning from a novice to advanced practitioner.

As a placement student in Physiotherapy, Ben [pseudonym] had been taught clinical skills but not employability skills. His knowledge and skills in the discipline were average. His mentoring was restricted to the supervision he received during his placement and the feedback on his placement performance. He was a highly motivated student pursuing his dream career as a physiotherapist, yet was an introvert and did not communicate his aspirations to anyone and so received no input on how to enter the arena of professionals and sustainable employability. When Ben entered the workforce as a 'qualified' physiotherapy professional, his problem solving and critical thinking skills were above average, he was self-motivated and would work to strict timelines. Ben continued to work hard but unfortunately his career progress was slow. In the absence of a mentor program at work, Ben felt unsupported. His day to day work was assessed via a Performance Appraisal which indicated little about his career progress or professional learning.

Ben is a typical example of an average physiotherapy student who meticulously follows the profession of his dreams, acquires adequate skills, knowledge and clinical practice to successfully pass his degree and yet has very little knowledge on employability skills/competencies, or career progression to be a successful professional. After completing seven years as a professional physiotherapist, Ben would rate on the AHCD framework Levels of Autonomy, as Level 2 for Initiative and Goal Orientation; Level 3 for Technology and Resource use; Level 1 for Learning and Reflecting; Levels 3 for Planning & Leadrship; Level 4 for Problem Solving and Critical Thinking; Level 1 for Communication and Professionalism.

DISCUSSION

Allied health professionals are required to be reflective practitioners and persistently generate knowledge to maintain competency and professional learning (Terry & Higgs, 1993). Yet, the course structures (physiotherapy) reviewed at Australian universities (Australian Physiotherapy Council, 2011) indicate little detail on the nature of acquiring experiential knowledge in the workplace or in the application of reflective practices and goal setting. Therefore, while the perception of academic preparation for entry to professions is to equip graduates with basic skills, knowledge and behaviours, the employers' perception of work place preparedness focuses on professionalism, perspective and confidence (Sole et al., 2012).

Furthermore, the Australian Standards for Physiotherapists (Australian Physiotherapy Council, 2006) and other employability frameworks (Cleary et al., 2006) indicate professional standards or competencies but do not necessarily provide the practical applications of those standards in the workforce. This leaves a gap between knowing and doing. Employers assume a level of competence in novice practitioners since they would have met the professional registration criteria. Yet, 'there appeared to be a conflict between level of skill and the level of confidence in the profession' (Sole et al, 2012, p. 125). Employers have referred to the lack of work skill preparedness (CSfW, 2013) as the contributing factor towards difficulties in decision making and lack of confidence in engaging. This highlights the importance of facilitating workplace readiness for novice practitioners.

The innovative Allied Health Career Development framework (AHCD) in this study, attempts to bridge the above gap in the transition from novice to advanced practitioner by:

1. Focusing and reflecting on competencies relevant to allied health professions
2. Applying sensitivity to the workplace via aspects of emotional intelligence (affective domain)
3. Building career progression through awareness in levels of autonomy
4. Using reflective practice for feedback

The AHCD is about self-directed learning and personal responsibility in recognising one's own strengths and limitations when applying the 'Personal Competencies' of - *Initiative & Goal Orientation* (Facet A), *Learning & Reflecting* (Facet C) together with 'Interpersonal Competencies' of *Technology & Resource Use* (Facet B), *Planning & Leadership* (Facet D), *Problem Solving & Critical Thinking* (Facet E) and *Communication & Professionalism* (Facet F). Professionals benefit from increased understanding of these facets by engaging in reflective practice and the *raison d'etre,* to progress in the hierarchy of lifelong learning and career development. The framework can also be used for example, in the adjustment of the health professional to reshaping needs of the health industry from changing demographic, political and economic situations, like ageing populations and the consequential need for greater communication and management skills to work with multi-faceted services in collaboration with health care teams.

The AHCD vs. Other Professional Frameworks

Generic frameworks on workplace performance to date, list only competency attributes (Dreyfus & Dreyfus, 1986; CSfW, 2013). The AHCD however, is distinctive in its inclusion of an associated competency, the affective domain (Bloom et al.,1956; Krathwohl et al., 1973) to incorporate sensitivity of the practitioner to the workplace (Goleman, 2000). The affective domain (EI), has been incorporated into the AHCD framework to emphasise the significance of personal behaviours and attitudes. Previously even though EI concepts have been implied in the workplace, they have not been identified as part of a professional development package. Freshman & Rubino (2002, p. 5) notes only select progressive health care facilities have recently recognised the value of EI training and incorporated programs to emphasise its principles.

While cross disciplinary employability frameworks list criteria under select work skill competencies (DEST, 2006), some frameworks monitor progress in the development of skills/competencies and provide acceptable levels for assessing the competency (Benner, 1984; Dreyfus & Dreyfus, 1986), while others refer to select competencies in key areas of professional practice (Beeston & Simons, 1996; Jensen et al., 2000; Ricker et al.,

2000; Titchen, 2000; Trede, 2006; Dunford, 2007; May et al., 1991). However, none relate these levels of autonomy to specific work skill competencies and sensitivity to the workplace, as does the AHCD. Autonomy is a key factor in the motivation to learn and build confidence. The AHCD allows the individual to assess and question the positioning at a particular level of autonomy, and then reflect and manage the desired level.

PROS & CONS of AHCD

The essence of AHCD is to create a more confident, goal oriented professional trained to focus on career development through the assistance of reflective practice and peer / mentor coaching. However in practice there could be impediments to the progress, and the need to be aware of such limitations and adjust accordingly.

1. Professional Development

Meeting standards in levels of autonomy is a component of Continuing Professional Development (CPD) where individuals take personal responsibility for identifying their learning needs and evaluating if those needs have been met (Hancox, 2002). CPD is a personal pedagogy that contributes to career progress and professional identity and is a learner-centred and a self-directed approach to learning (Grant & Stanton, 1998) and now, a requirement of registration in Australia (e.g. Physiotherapy Board of Australia, 2010).

Commitment to continuous learning and improvement is a core competency in itself. Therefore, in this study there is an expectation that a practitioner will adopt AHCD in assessing one's level of autonomy and continue to receive feedback from peers/mentors. The feedback via AHCD can also be used by employers in combination with other professional workplace assessments to monitor the progress of practitioners.

2. Reflective Practice

The AHCD is designed to facilitate the process of critical self-appraisal by reflection on each competency at a given level of autonomy. Reflection is considered one of the most important sources of personal professional development and improvement (Clouder, L., Donaghy, M.E., & Morss, K., 2007). Reflective practice is widely recognized in professional development for healthcare practitioners and believed to have wide application in leadership development (Schon, 1983). In reflective practice, practitioners engage in a continuous cycle of self-observation and self-evaluation in order to understand one's own actions and reactions. Reflective practice involves thinking critically about one's own actions and is a corner stone of continuing professional development (Clouder, 2000). In the current climate of accountability, health professionals are required to demonstrate evidence-based practice in the profession.

3. Peer/Mentor Coaching

Ladyshewsky (2010) believes that although it is important for a novice practitioner to demonstrate their competence to practice at an individual level, the journey towards achieving that competence should not be attempted alone, but rather with peer (mentor) coaching. He says confidence grows by seeking feedback from 'others' about knowledge, skills and attitudes towards professional practice (Ladyshewsky, 2010, p.e-77). In this respect, AHCD can be used as a self-assessment tool or a performance feedback tool for the employer, as adopted by the WSD (Bandaranaike & Willison, 2010). The AHCD therefore encourages regular self-assessment and management of one's career, giving a greater sense of fulfilment and satisfaction (Black et al., 2010). Through experiential learning (Kolb, 1984) and reflective practice (Schon, 1983) the individual transfers experience in the workplace to evolve career pathways. The AHCD facilitates this process as it guides the individual to reflect and receive feedback on their performance in the workplace either with the guidance of mentors/peers or be self-administered. Peer feedback is viewed as a powerful formative assessment strategy associated with increased job satisfaction (Ladyshewsky, 2010) and firmer career plans and promotions (Wright & Wright, 1987). Wainwright et al., (2010) describes the importance of mentorship for developing decision making skills as a cornerstone of effective patient care, since mentors facilitate attributes such as

effective communication, commitment to learning, and confidence. Similarly studies of novice nurses showed that six months to one year of work in the clinical environment increased both professional behaviours and confidence (Black et al., 2010; Clark & Holmes, 2007). This emphasises the importance of time and clinical experience to strengthen confidence. It also suggests that whilst generic attributes can be developed within an undergraduate programme, they require further development and facilitation on employment.

4. Limitations

- In self-assessing Levels of Autonomy, susceptibility to faking higher levels of performance is a possibility as is the case in most other self-administered / self-reported measures. However, if individuals value their career development and value accurate appraisal then obviously an honest evaluation would be to their benefit. This glitch can be overcome when the framework is evaluated together with peers or mentors.
- The need to effectively guide the practitioner via overseeing mentors/peers could be an issue when considering time commitments and other duties in the workplace .
- Motivation and diligence for effective disciplined reflective practice can be visualised as a possible issue for some individuals.
- At the time of writing, the AHCD has not been trialed as yet in the workplace to assess its effectiveness and/or limitations. However, the Work Skills Development Framework (WSD), a sister framework of AHCD, has been successfully trialed (Bandaranaike & Willison, 2010) with Work Integrated Learning (WIL) students. In addition, an online tool accompanied by a series of self-administered reflective questions on work skill competencies to assess active levels of autonomy in pre and post placement is currently being developed using the WSD as the base (Torres et al., 2014). It is therefore envisaged that the future developments of AHCD will be on these lines.

CONCLUSION

Employability is not about just possessing skills and knowledge of a discipline, but knowing how to convert that knowledge to workplace applicability. The objective of the AHCD was to facilitate the successful transition of an allied health professional from novice to advanced practitioner while focussing on key competencies and levels of autonomy through reflective practice and emotional and social sensitivity to the workplace. In accomplishing this task, the theoretical basis and the practical application of the AHCD has been discussed in this paper in terms of training the practitioner to reflect and experience discipline specific work related competencies, and review and evaluate progress by applying benchmark criteria provided at each level of autonomy in the cell descriptors of the framework developed in this study. The AHCD facilitates this transition via self-directed learning and reflective practice. The overall effect is a more satisfied, confident practitioner with a sustainable career for life.

A practical strength of the AHCD lies in the use of self-directed learning, reflective practice and the incorporation of EI concepts. Practice of EI makes professionals more cognizant of interpersonal and intrapersonal relationships (Goleman, 1998; Mayer and Slovenski, 1997). The future expectations with health professionals will be continuing high standards of practice and the ability to work on their own initiative with an orientation and ability to engage in lifelong learning and reflection on career development. In the current economic and political climate, mentor/peer assistance is likely to be reduced owing to limited resource availability. Therefore a self-administered, self-directed learning tool such as the AHCD will be of significant benefit to allied health professionals and employers.

The philosophy presented in the framework is valuable to all professionals and their career development aspirations. The Allied Health Career Development framework (AHCD) in the words of Abraham Maslow (1943) is "*what a man can be, he must be".*

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