**REPORT:**

**Student-Led Clinical Services within the University Health Clinic: Definition, educational practices and outcomes**

ABSTRACT

Increasingly, universities are allocating substantial resources and efforts toward developing their own Student-Led Clinical Services (SLCS) within University Health Clinics (UHCs).   
For that reason, under the umbrella of the Australian and New Zealand Association of Health Professional Educators (ANZAPHE), clinical educationalists from twelve Australian universities have come together as a Hot Topic Action Group (HTAG) to collaboratively explore and enhance learning outcomes from this setting.

SLCS within UHCs increase placement capacity to meet growing demand. Moreover, SLCS within UHCs have the potential to provide an outstanding learning opportunity through high-quality supervision and activities designed to develop clinical competencies. However, in a formal sense, we know little about the benefits of providing clinical education experiences in this setting.

Typically, SLCS within UHCs are developed in consultation between university and local health providers and are purposefully designed clinical placements with a focus on clinical educational activities for pre-professional students. UHCs may be located on or off-campus and offer SLCS or other services to university staff, students and/or the wider community. In SLCS students are supervised in the delivery of the health service by university employed health professionals.

The work of the HTAG to date presented in this paper, defines the setting, outlines assumptions, aspirations, challenges and enablers. The next phase of work for the HTAG is to formally explore the educational value of SLCS delivered in UHCs and develop resources and a Quality Assurance Framework to guide the evaluation of these services.

**Key words**: University clinics; student-led clinical services; clinical education

**Introduction**

Increasingly universities are allocating substantial resources and efforts toward developing their own clinics – University Health Clinics (UHCs). At face value UHCs provide valuable teaching and learning environments for university students – mainly, but not only, via student participation in Student-Led Clinical Services (SLCS). The experience of HTAG members who are involved in this setting indicates SLCS are offered as a means of operationalising the universities’ tripartite mission of engagement with the community by offering a health service to the university and local community, providing opportunities for research and for students to participate in clinical experiential education. In doing so, SLCS in UHCs provide a vehicle for the universities to demonstrate the axiom: *University for the common good*.

Examples of UHCs are seen internationally as well as in Australia. In the United States student-run clinics provide services where healthcare is not traditionally funded, such as health services for homeless populations (Meah, Smith, & Thomas, 2009; Palombaro, Dole, & Lattanzi, 2011). Whereas the University of Calgary, Canada adopts the view that student-run clinics contribute to the faculty’s mandates of re-education, service to society, and social accountability (Campbell, Gibson, O’Neill, & Thurston, 2013).

In Australia SLCS provide opportunities for Universities to service the community through programs such as school health checks, indigenous health screening, staff health checks, rehabilitation for recovery from stroke, manual therapies and services for children with developmental delays. SLCS provide educational opportunities for students who are in various stages of their studies and involve students in both undergraduate and graduate entry Masters’ Programs.

Under the umbrella of the Australian and New Zealand Association of Health Professional Educators (ANZAPHE), clinical educationalists from twelve universities have come together as a Hot Topic Action Group (HTAG) to focus on exploring and improving clinical education within UHCs. Our aim is to grow the HTAG collaborative network to develop best practice frameworks and resources to contribute to the evidence base that supports clinical education in UHCs. Our objective is to explore the clinical educational procedures, practices and outcomes of UHCs, to illuminate the extent to which student activities within UHCs support students’ acquisition of the desired professional and employability competencies.

**Context**

Among the HTAG, we share a view that SLCS within UHCs help address placement shortages experienced in a number of health professions (Bacon, Williams, Grealish, & Jamieson, 2015; Barnett et al., 2008; Burrows et al., 2013). It is felt that SLCS in UHCs can prepare students for or compliment clinical education undertaken at external placement sites.

Schuttle et al’s (2015) systematic review of learning in student-run clinics in medicine reported high student satisfaction with learning, drew no conclusions about the extent of students’ skill development, knowledge and behaviours (Schutte et al., 2015). An earlier study in physiotherapy (Nicole, Fairbrother, Nagarajun, Blackford, & McAllister, 2014) confirmed student can develop competencies through SLCS. Another in dietetic clinical education, confirmed that students can develop and demonstrate professional competencies within non-hospital placements (Bacon, Williams, & Grealish, 2015).

SLCS within UHCs are not only thought to increase placement capacity to meet growing demand, they also provide an optimal environment that enables peer-learning and inter-professional education (Copley et al., 2007). SLCS within UHCs are well placed to exemplify best practice clinical learning environments, providing learning experiences that nurture students’ development as independent thinkers and competency and confident health professionals. Some SLCS provide a first introduction to clinical placements and preparation for later stage community based placements while other are the main clinical learning site for students during studies at the specific institution. Yet to date, we have limited evidence of the value of particular clinical education models, procedures, processes or the outcomes achieved through these unique clinics.

SLCS are typically, set up with the primary aim of educating students in a supportive learning environment and, in some instances to fill service gaps (Nicole et al., 2014). External businesses are required to adopt a business model that returns a profit for financial viability, whereas, in the experience of the members of the HTAG, SLCS in UHCs are most often non-profit because the primary focus is to provide clinical placement education. Even so, the costs of administration, resources, insurances, space, equipment and governance need to be offset, plus, the costs of clinical educators who guide the students and provide feedback and / or assessment. Whether clinical training that occurs within a UHC is at a greater or lesser cost, educationally superior or just as effective as external placements, remains unknown. That said, many of the HTAG members are proactive in undertaking the research in their own disciplines and context to explore these issues.

Discourse among HTAG members has clarified that, within our footprints faculty appear to make two assumptions about clinical education in UHCs. Neither of these are well supported by the available literature. Our first assumption is that the education provided in a UHC, which may operate as a SLCS, is educationally effective, that it enhances personalised learning, that it is of a high and consistent standard and that opportunities to support ‘at risk’ students are readily available. In this setting the curriculum is organised to provide a comprehensive clinical education experience, providing regular formative and summative assessments – thus poor student performance can be quickly identified and remedial educational activities scaffolded to support at-risk student’s learning needs to bring him or her up to the required standards. Our second assumption is that UHCs provide an ideal environment to support inter-professional training, particularly when many clinics operate within the Faculties of Health and have several professions training within the clinic. Yet, the extent and range of inter-professional SLCS operating within UHCs is not yet known.

**Definitions**

UHCs are health clinics which fall under university governance and are developed in consultation between university and local health providers. They are purposefully designed clinical placements and aspire to a concurrent focus on education, healthcare and research and community service. UHCs are located either on or off-campus, they offer SLCS and may also offer other services to university staff, students and or the wider community. In SLCS students are supervised in the delivery of the health service by qualified health professionals who are contracted by the university. The business models of SLCS in UHCs vary and may include a financial imperative to be viable as a business or, may be non-profit, subsidised by the Universities.   
Guidelines for what defines a SLCS in a UHC are not clear and for this reason, the frame of reference the HTAG members have adopted has been informed by the guidelines of Tertiary Education Quality and Standards Agency (TEQSA) re the Higher Education Standards Framework (Threshold Standards) 2015: Domains1-6 and the Guidance Note: Work-Integrated Learning. (Australian Tertiary Education Quality and Standards Agency, 2015, 2017).

SLCS can include models developed within existing services to overcome unmet service provisions (Nicole et al., 2015). Supervisors do not carry their own case load and focus on providing student support in a just-in-time manner, while at the same time the students progressively move towards independence (Bostick, Hall, & Miciak, 2014). SLCS provide the opportunity for students to improve their clinical reasoning skills, history taking skills and physical examination and interpretation skills (Campbell et al., 2013; Warner, Jelinek, & Davidson, 2010).

There is a view that student-led clinical learning may offer pedagogical advantages similar to problem–based learning – though this has not been confirmed (Bostick et al., 2014). Copley et al (2007) references Whitlam, in saying the two key theoretical elements underpinning the approach in student-run clinics are built on the notion of cognitive constructivism: the promotion of student independence and active learning (Copley et al., 2007; Whitman, 1993).

In clinical placements hosted within existing health services, the focus of activities is on providing clinical services, with the student learning needs managed within the context of existing time and resource constraints. In comparison, according to recent authors, SLCS can be considered learner-centred because all clients understand and are respectful of students’ need to learn (Barrow & McKimm, 2010; Bostick et al., 2014). Students perceive SLCS to be safe places to learn and they have a sense of ownership and responsibility (Bostick et al., 2014; Kavanagh, Kearns, & McGarry, 2015). A report of dietetic students learning interview skills in in a UHC at the University of the Sunshine Coast claimed students were able to discover the nuances of practice and develop people skills and confidence (Swanepoel, Tweedie, & Maher, 2016).

A snapshot for the scale of SLCS in UHCs within the footprint of the authors of this paper is below in Table 1.

INSERT TABLE 1

**Benefits**

The educational and health services provided by students through UHCs be they on or off campus, are generally planned in collaboration with local communities. These are mostly in urban locations but sometimes provide healthcare in underserviced areas through remote clinics (Allan, O’Meara, Pope, Higgs, & Kent, 2011). SLCS in UHCs can assist in addressing placement or workforce shortages in underserviced areas and through this can demonstrate the value of the profession to the community (Bacon, Williams, Grealish, et al., 2015). The HTAG members agree the benefits of SLCS in UHCs are that they benefit:

1. *Junior students*Early on in the curriculum, students can have an early exposure to the profession and start forming a professional identity and begin thinking like a professional*.* Learning activities, if so designed, may better assist students to establish their own identity, to set career expectations and to identify what is required in the latter years of their courses. These opportunities connect students earlier in the course, to the relevance of their learning which in turn encourages them to set more future focused goals that can enhance success.
2. *Senior students*SLCS in UHCs are important for senior students, as in the typical educational activities therein students are accountable for their contribution to health service delivery, under the supervision of registered health professionals. Similarly, and in relation to clinic operations, Sheu et al’s (2013) study in medicine demonstrated that student-run clinics provide students with an appreciation of the overall function of a health clinic and their complexity, limited resources and, their context within the wider health care system (Sheu, O’Brien, O’Sullivan, Kwong, & Lai, 2013).
3. *Educationalists*SLCS provide an opportunity to implement and evaluate new models of service and or models of supervision that are informed by evidence based research (Allan et al., 2011; Bacon, Williams, Grealish, et al., 2015; Burrows et al., 2013).
4. *Inter-professional learning*   
   In UHCs students often work in collaboration with students from other health professions, for example: the student-led inter-professional clinic in primary care (Diabetes care) Monash University (Kent & Keating, 2013); Curtin University’s team-based inter-professional practice program (Brewer & Barr, 2016) and; the University of Queensland’s clinic which hosts occupational therapy, speech pathology and music therapy services (Copley et al., 2007).
5. *Clinical educators*The University can directly select staff who are both high quality educators and clinicians. UHCs can provide an incubator for new graduates and alumni wanting to begin a teaching career and can also provide an avenue for full-time academics to maintain clinical currency. UHCs can and do attract experienced practitioners, who do not want to engage in full academic life and, those without formal research backgrounds who, nevertheless, have substantial clinical knowledge and skill to contribute to the delivery of the clinical curriculum.

**Challenges**

Although there are many benefits of UHCs, there are clear challenges to this type of clinical education. A seminal paper in 2008 identified and published the challenges for outpatient clinics in general (Ramani & Leinster, 2008), see Box 1, and these are similar in nature to the clinics - SLCS offered within UHCs. Ramani and Leinster wrote the challenges of outpatient’s clinics are:

INSERT BOX 1

The HTAG members regard the other challenges of SLCS in UHCs are the:

1. *Student availability*   
   One key challenge to organising SLCS in UHCs is managing clinical operations in conjunction with the academic timetable. For example, students are not always available to be rostered to clinic during examination periods and semester breaks – hence research has identified student unavailability to sustain the SLCS offering, may affect the continuity of client care over the calendar year (Campbell et al., 2013; Kavanagh et al., 2015). If the clinical placements are organised in block mode, for example two 6-week blocks per year, it can be difficult for SLCS to build and maintain client numbers, provide continuity of care and provide optimal care for clients. SLCS work best if students are organised to attend longitudinal placements, say one afternoon a week for the semester.
2. *Clinical educator availability*  
   Similar to the above, sourcing, training, and retaining clinical educators to supervise student clinical placements across the full calendar year can be challenging, as can having adequate clinical space and equipment (Bostick et al., 2014; Kavanagh et al., 2015; Smith et al., 2014).
3. *Costs*  
   The financial arrangements for clients in SLCS does mean students are not orientated to different insurance funding models for professional health service delivery. UHCs typically rely on clients who are prepared to self-fund treatments because third-party payments from for example: Department of Veteran Affairs, Motor Vehicle Accident, Workers Compensation, Medicare, and private health insurance companies, do not refund health services provided by students. The good news is that for the clients attending SLCS who have no private health or other insurance SLCS can provide them with a low-cost service option.

Another consequence of the low fee for SLCS is that a low fee-for-service (or no fee-for-service) may be that it creates different client expectations, be they positive or negative about the effectiveness and efficiency of student-led treatment. Experience tells us that within private practice settings, where clients pay full fees their expectations can be higher, and if clients are not satisfied with the value for money offered, they will go elsewhere and this teaches students about organising and managing a viable business. Furthermore, feedback from clients to students during SLCS has been identified as being overly positive rather than objective (Burrows et al., 2013; Moore, 2012) and this can potentially lead to students developing a false sense of their clinical skill and capabilities.

1. *University-community relationships*

Tensions have been known to develop between the university and local health care providers who regard SLCS as unfair competition because of the low fee for service. In some situations, this has lessened the pool of a) available clinical educators from the local area, because health professionals don’t want to be associated and support the enterprise and business model and b) the offerings from health professionals in the local area to take students for external clinical placements.

1. *Financial sustainability*The elements making up the costs of running a health service are generally understood in a given situation and when the service is provided by students and qualified health professionals, clinical educators and the associated education resources costs need to be factored in. Any study of the cost benefit analysis needs to consider there is likely to be a longer consultation time with additional costs related to evaluation and assessment of student’s performance, plus time for discussion, tutorials and feedback. The fiscal tensions and competing priorities between costs for the supply of clinical services and income, and the costs of resourcing the student learning experiences has been discussed by others (Haines, Isles, Jones, & Jull, 2011), but not in relation to SLCS in UHCs.

**Essential elements of quality SLCS in UHCs**

The now disestablished Health Workforce Australia published the elements of quality in clinical placements (Siggins Miller Consultants, 2012) and that information together with the considered opinions of the HTAG members suggest there are three key enablers for effective and efficient SLCS in UHCs. The essential elements of success are prior preparation and planning which includes the:

1. *Consideration of resource implications*

Consideration needs to be given to the:

* Training of staff to be high quality clinical educators.
* Financial or in-kind contributions, if required, to set up the environment for student presence. Also, a sustained commitment to the clinic by the University.
* Commitment to:
  + University professional clinical educator or inter-professional facilitator (as a super-numerary position to academic appointments within a program).
  + Dedicated academic leadership position within the university who can bridge the gap between coursework and clinical learning and act as a champion for clinical education (CE) / inter-professional learning models in authentic practice environments.
  + Time for the design, implementation and evaluation processes including the development of a theoretical practice and learning framework which guides the day to day activities of the UHC, so that best- and evidence-based practices are being implemented and continually evaluated using quantitative and qualitative methods.
* Access:
  + For UHC students to physical resources to facilitate learning (i.e. space, tables, chairs, whiteboards, lockers, internet access etc.)
  + For UHC clinical staff to professional development funding as per other academic staff.
  + For UHC organisers to the University marketing initiatives which aligns to the professional advertising standards of the associated health professions.

1. *University – community partnership*    
   Commitment both from bottom up and top down within the organisations involved is critical, especially if the clinic engages external partners to run the clinic or provide the service to the community. Stakeholders need to work together to ensure the relationship is mutually beneficial and realises the universities strategic plan and policies. All partner organisations of the UHC should commit to:

* A formal legal agreement with the university regarding clinical education priorities, practices and responsibilities of all parties.
* Continuous quality improvement that is aligned to the relevant health professional standards and the university quality cycle (i.e. TEQSA) to enhance outcomes and minimise risk to all stakeholders.
* Developing a financial model (e.g. low fee-for-service model) with appropriate referral pathways for clients.

1. *Collaboration and support from all stakeholders*

Collaboration needs to be sought with a variety of university stakeholders through standard items on appropriate committee agendas concerning:

* The development of the university community engagement plan to facilitate the participation of key stakeholders. Use of a defined model for stakeholder engagement. See (International Association of Public Participation, 2016) to map the engagement strategies of; informing, consulting, involving, collaborating and empowering.
* Course accreditation: Involvement of relevant health professional program accrediting bodies and university clinical staff so that the UHC targets gaps in placement availability.
* Outreach clinical services: Consideration of UHC services being embedded in non-traditional environments (e.g. schools or aged care facilities) so that additional funding partners can be considered. (i.e. government, non-government-organisations and philanthropic bodies).
* Timetabling, so that client care can be provided by student-led services year-round and this may mean working with other universities.

**Future activities of the HTAG**

Notwithstanding the many challenges of organising and managing a SLCS in a UHCs they have the potential to realise the university aspirations to work with industry and community, to offer quality clinical education experiences to ensure health graduates are fit for purpose to provide high-quality healthcare services to communities.

Going forward, the next activities of the HTAG are to develop a Quality Assurance (QAF) Framework. The QA Framework will include strategies for answering previously unanswered questions such as but not limited to a cost-benefit analysis, a study of inter-professional clinical education models and an exploration of what students regard as the benefits of an education through this unique educational setting. Our findings will potentially contribute to debate regarding a nationally consistent approach to the funding and management of UHCs through clinical training funds, with consideration being given to allocating a protected component of clinical placement costs.

**Conclusion**

In a formal sense, we know little about the benefits of providing health and medical students clinical education through SLCS in UHC. The HTAG members have defined the setting and outlined the aspirations, challenges and enablers. Future work of the HTAG group will be to develop resources and identify a Quality Assurance Framework (QAF) which will include strategies confirm or deny our assumptions that within this unique setting: that the education provided is effective and enhances personalised learning, is of high-quality and provides mechanisms for the early detection of and effective interventions for ‘at risk’ students and; that UHCs provide an ideal environment to support inter-professional training. Also included in the QAF will be strategies to identify: the cost-benefit analysis; the educational value of different clinical education models and; an evaluation framework for identifying stakeholder’s views of the benefits challenges and enablers of an education through this unique health education setting. We now look to our colleagues for their contribution, assistance and comment.

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Table 1. A snapshot of Student-led Clinical Services in University Health Clinics

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| **University** | **Student-led Clinic Services in the University Health Clinics** | **Location of Clinics** |
| Bond University | Physiotherapy, Psychology, Exercise and Sports Science, Nutrition, Dietetics | Robina, QLD  On Campus |
| Curtin University | Physiotherapy, Occupational Therapy, Speech Pathology, Exercise & Sports Science, Nursing, Professional Psychology, Counselling Psychology, Social Work, Pharmacy, Dietetics | Perth, WA |
| Edith Cowan University | Dietetics, Exercise & Sports Science, Exercise Physiology, Psychology, Occupational Therapy, Speech Pathology | Perth, WA.  On campus |
| Griffith University | Dentistry, Dietetics, Exercise Physiology, Physiotherapy, Psychology, Speech Pathology | Gold Coast, QLD |
| Queensland University of Technology | Exercise Physiology, Nutrition, Dietetics, Podiatry, Optometry, Psychology, Counselling, Social Work, Nursing | Kelvin Grove, Brisbane, QLD.  On campus |
| Southern Cross University | Occupational Therapy, Speech Pathology, Clinical Exercise Physiology, Podiatry, Pedorthics, Osteopathy  Other health professions in theSchool that do not offer student-led clinics are: Nursing and Midwifery. | Lismore, NSW, Coolangatta, QLD. |
| University of Canberra | Musculoskeletal Physiotherapy, Neurological and Falls Physiotherapy, Exercise Physiology, Nutrition and Dietetics, Occupational Therapy, Psychology, Counselling | Bruce, ACT, On campus |
| Victoria University | Osteopathy, Nutritional Therapy, Dermal Sciences, Psychology, Social Work. Other Clinical Professions: Nursing, Midwifery, Paramedic Sciences | Melbourne CBD, St Albans, Werribee Vic. |

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| **BOX 1 Challenges of outpatient teaching** |
| Busy clinical setting |
| Teaching time often short, no time for elaborate teaching |
| No control over distribution and organization of time |
| Attending to several clients at the same time with multiple learners |
| Brief teacher-trainee interactions |
| Client care demands usually take priority and must be addressed |
| Multiple client problems must be addressed simultaneously, so teachers cannot focus on one problem to teach |
| Learning and service take place concurrently |
| Organic and psychosocial problems are intertwined |
| Diagnostic questions often settled by follow up of empiric treatment |
| Teacher should be a guide and facilitator than information provide |

(Ramani & Leinster, 2008)(p.351)