

Patient and practitioner perceptions of student participation in private practice consultations: A mixed-methods study

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Abstract

The majority of undergraduate physiotherapy clinical education occurs in the public sector in Australia, despite the fact that about half of all graduates enter private practice upon graduation. Private practice physiotherapists provide primary care services for a wide range of conditions, with associated opportunities for student education. The barriers to addressing the imbalance between clinical education and graduate practice warrant investigation. This study combined quantitative patient survey data with qualitative practitioner interview data. Sixty-three patient surveys were collected from four private practices, and practitioner educators (n=4) at these sites were interviewed. The survey data revealed that patients tend to be agreeable to student presence in a consultation but expressed varying preferences regarding the degree of student involvement in their care. Practitioners reported benefits associated with taking on an educator role, including screening students for future recruitment. They also reported barriers to increasing education opportunities for education in private practice, including lack of time, cost and limited skills of students. A need to better prepare practitioners for the role of educator was identified. In conclusion, there is a subset of private practice patients that is agreeable to students providing health services. Routine identification of these patients, and better preparation of both educators and students, may improve the current lack of clinical learning opportunities in private, primary care and physiotherapy clinics.

Keywords: education, patient perspective, physiotherapy, private practice, undergraduate.

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Introduction

Clinical education is an integral part of physiotherapy education. Matching pre-entry clinical education experiences to workforce needs is important in the development of well-prepared graduates. A substantial amount of physiotherapy and medical education occurs in the public sector, particularly in hospitals, despite the ongoing shift in healthcare to community services (Dean et al., 2009; HWA, 2013). Around 50% of physiotherapy graduates work in private practice after graduation (Mulcahy, Jones, Strauss, & Cooper, 2010), yet in Victoria in 2012, only 5% of physiotherapy placements were in private practice settings (HWA, 2013). Private physiotherapy practices provide services for a broad spectrum of conditions. Practice placements in such environments would be valuable in preparing well-rounded entry-level practitioners. Anecdotal reasons for the lack of student placements in private practice settings include: paying clients are not agreeable to student care, students lack skills for private practice and teaching slows patient throughput and results in a cost to the business. Little evidence confirms these concerns.

In 2010, Physiotherapy Business Australia (PBA), submitted a report to the Council of Physiotherapy Deans (CPDANZ) arguing for greater input by private practitioners in preparing students for entry-level physiotherapy practice. PBA argued that exposure of pre-entry-level students to private practice is important, but their members reported numerous barriers that restrict private practice placements. These included, but were not limited to, regulatory issues, legislative issues, loss of remuneration from reduced patient payment, reduced staff output, requirements for health fund rebates, maintenance of service excellence, patients not wanting to pay for student treatment, size and layout of clinics, number of staff, professional indemnity implications, lack of practitioner preparation for the role of clinical educator and inconsistency in methods used to assess students. These concerns echo those reported about education in physiotherapy private practice in Canada and general medical practice in Australia (Doubt, Paterson, & O'Riordan, 2004; Thistlethwaite, Jacobs, & Rudolph, 2005). To optimise student learning opportunities in private practice settings, the concerns of key stakeholders must first be understood.

As part of a larger project designed to better align student preparation and clinical education experiences with the skills required for the delivery of healthcare in Australia, this study investigated barriers that limit student involvement in the private sector. The specific aims of this part of the study were to determine:

1. Patients' views about students providing care in private practice settings
2. Patient preferences in regard to the type of activities performed by students within private practice settings
3. Practitioner perceptions of student participation in private practice settings.

Method

A mixed-methods approach was utilised, gathering data from surveys and interviews. All private practices with any engagement (current or previous) in entry-level education of physiotherapy students in the region of Frankston, Victoria, Australia,

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were invited by email to participate (n=8). Practitioners from consenting practices were then invited to collect 25 consumer surveys over a 1-month period and attend a structured interview.

In Part 1, participants were adults (over 18 years) who attended consenting practices within the 1-month survey period. Consenting patients were offered the *Participant Information Form* and an anonymous one-page survey by either the reception staff or treating physiotherapist, depending on the practice preference. Patients who elected to participate placed completed surveys in a sealed envelope and returned them to reception prior to leaving the practice. The number of patients who declined participation in the survey was not recorded.

The patient survey design was informed by the medical education literature that describes patient perspectives of student participation in general practice (Bentham et al., 1999; Choudhury, Moosa, Cushing, & Bestwick, 2006; Cooke et al., 1996; Klakovic & Parrkin, 2002; Simons, Imboden, & Martel, 1995; Sweeney, Magin, & Pond, 2010). The one-page survey investigated the degree of patients' acceptance of student care in a private physiotherapy consultation and itemised eight aspects of a physiotherapy consultation for consideration with respect to student involvement. Response options were on a 4-point scale (very comfortable, somewhat comfortable, not at all comfortable, unsure). Patient age and gender, the body part being assessed and the consideration of student gender in patient consent were also considered, as these issues have been previously recognised as relevant to clinical education in general medical practice (Bentham et al., 1999; Choudhury et al., 2006; Klakovic & Parrkin, 2002; Simons et al., 1995; Sweeney et al., 2010). The survey also specifically asked patients the following questions with free-text response options: "Do you think that there are any benefits for you in allowing physiotherapy student involvement in your consultation?" and "Do you think that there are any negative aspects for you in allowing physiotherapy student involvement in your consultation?"

In Part 2, practitioners from consenting practices were invited to participate in an interview to discuss teaching undergraduate students in a private practice setting. The aims of the interviews were to determine what practitioners perceived to be the benefits, concerns, current education practices and areas for improvement in undergraduate clinical education. Predefined questions were used to stimulate free discussion. The interviews were conducted by two members of the research team: a physiotherapist (who was not an employee of the university physiotherapy department) and a medical practitioner. Interviews were audiotaped and transcribed verbatim. They were analysed using thematic analysis (Miles & Huberman, 1994) by two researchers (FK and KR), and key themes were agreed by discussion, then coded using NVivo software. Quantitative survey data were analysed using SPSS*.

This research received the approval of the Monash University Standing Committee for Ethical Research on Humans (CF12/2425-2012001313).

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Results

Patient and practitioner perspectives were obtained from four private physiotherapy practices. Each practice had multiple employees with experience in undergraduate education. Each practice agreed to collect patient data over a 1-month period and participate in a practitioner interview. The participating practices offered students exposure to a diverse range of musculoskeletal disorders and a younger patient group than would be experienced in the corresponding public health setting (Table 1) (Kent & Molloy, 2013).

Part 1: Patient survey outcomes

Sixty-three patients completed surveys (Table 1).

Eleven patients (18%) had received treatment from a student at the private practice in the past, and 9 (82%) of these patients reported the quality of the consultation to be the same as usual care, one reporting improved quality of care, and one reporting reduced quality of care:

Treatment was professional and certainly helped [me to] recover. (#25, positive)

I don't get qualified treatment and my physio wastes appointment time by explaining stuff to the student. (#13, negative)

Table 1
Patient Demographics (n = 63)

	N (%)	Not comfortable with an aspect of student care n (% of total N)
Female	31 (49%)	7 (22%)
Male	27 (43%)	3 (11%)
Missing	5 (8%)	
Age group		
18–40	19 (30%)	4 (21%)
41–60	28 (44%)	5 (18%)
60–79	15 (24%)	1 (7%)
80+	1 (2%)	0 (0%)
Reason for consultation		
Multiple/other	18 (29%)	4 (22%)
Shoulder	12 (19%)	0 (0%)
Back	9 (14%)	1 (11%)
Ankle	7 (11%)	1 (14%)
Knee	6 (10%)	1 (17%)
Hip	6 (10%)	0 (0%)
Neck	4 (6%)	3 (75%)
Elbow	1 (2%)	0 (0%)

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For those patients who had not consulted a student in the past, 34 (65%) expected the consultation to be the same with student involvement, 4 (8%) expected improved quality, 4 (8%) expected reduced quality and 10 (19%) reported they were “unsure”:

I assume with supervision it would be the same. (#16, neutral)

Session would still be controlled by a qualified physio. If explanations are being given to the student, I may also pick up more info. (#8, positive)

Second opinion, new techniques and procedures. (#31, positive)

Do not know my history and past experience as well as my normal physio. (#2, negative)

The degree of comfort with student participation is reported in Figure 1. The gender of the student affected patients’ decisions to involve students in nine (14%) cases, usually related to concerns regarding the part of their body that was being examined. Patients also reported that if a cheaper student-led consultation was offered, 14 (23%) would consider seeing a student instead of their usual clinician, 43 (71%) would not, 3 (5%) were unsure and 1 (2%) said it would depend on the problem.

Age, gender and reason for consultation were reviewed for all patients who responded that they were “not comfortable” with at least one aspect of student participation (Table 2).

Qualitative themes from patient surveys.

Benefits of student involvement.

In support of student participation, patients commonly acknowledged the importance for learners gaining practical experience and altruistically wanted to support student learning:

Yes, they are the physios of the future and need to have “hands on” experience. (#52)

It would benefit me if I knew that I was helping the student. (#44)

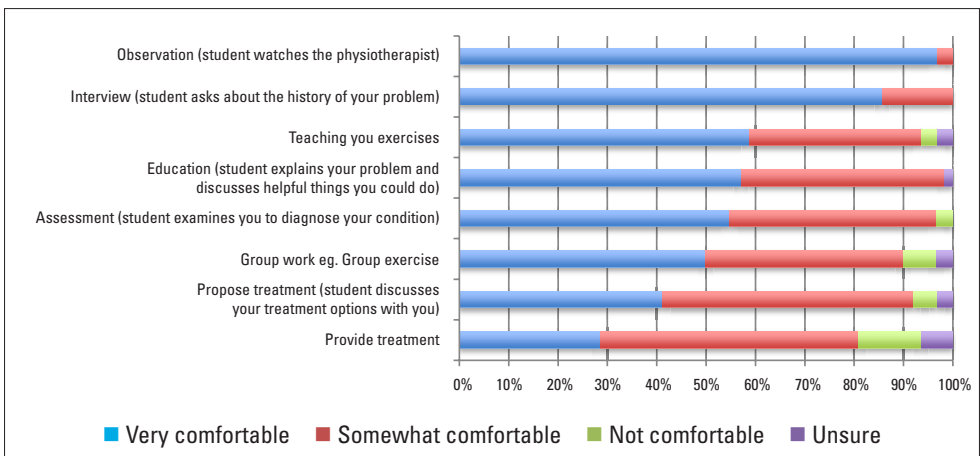


Figure 1. Patient level of comfort with type of student involvement in consultation (n=63).

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Table 2
Breakdown of Patient Demographics for Patients Uncomfortable with Student Care

Age	Sex	Reason for consultation	Aspect of consultation not comfortable with student involvement
18–40	F	neck and back	provide treatment group work teach exercises
18–40	F	knee	provide treatment group work teach exercises
18–40	M	ankle/foot	assessment propose treatment provide treatment
18–40	M	other	group work
41–60	F	neck	propose treatment provide treatment
41–60	M	back	group work
41–60	F	neck and knee	provide treatment
41–60	F	back and hip	assessment propose treatment provide treatment
41–60	F	neck	provide treatment
61–79	F	neck	provide treatment

Final year students are at the end of their training, all they lack is experience—they need to gain this somewhere, some time, why not under the guidance of an experienced qualified physio. (#46)

Some patients also valued the opportunity for a second opinion (from the student), while others noted that the student may offer more up to date treatment ideas:

A second set of eyes and ideas is always good. (#36)

They may see something different, new ideas. (#18)

Concerns related to student involvement.

A considerable number of patients indicated that their willingness for student involvement was dependent on adequate supervision by a qualified physiotherapist.

A few expressed concern that the student’s lack of experience could be “risky”, resulting in delivery of an incorrect treatment:

All ... fine, provided students are supervised by a qualified physio. (#8)

Quality [of the treatment] depends on quality and professionalism of qualified physio and their ability to instruct and treat at the same time. (#15)

I have a very complicated back and wouldn't like advice from a young inexperienced student. (#28)

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Part 2: Practitioner interview

Four practitioners, one from each of the four practices that had collected patient surveys, participated in a 1-hour semi-structured interview. One interview was held with two clinicians concurrently; the other two were held individually.

Qualitative themes from practitioner interviews.***Patients' perceptions of students.***

In general, practitioners reported that patients are positive towards students as “observers” in their private practices, with patients often engaging the students in conversation. However, the practitioners also reported that patients' willingness for students to be involved in their care was variable:

I think you have got three [patient] views: those that prefer not, those that love it and those that don't give a damn ... In private practice, most of them are happy to have a student come and observe. How much they want to then ... let them do varies. (P3)

Practitioners also reported that patients are positive about their treating clinician taking an educator role.

The practitioners reported that patient expectations of their business limited opportunities for student engagement:

People are paying pretty good money and time to come, and I suppose they [... have expectations regarding how they] ... want to be treated. (P4).

The practitioners reported carefully selecting appropriate patients for student consultations, based on their knowledge of the patient, their degree of comfort and security in their patient–therapist relationship and the patients' anticipated acceptance of student care. In the case of a new patient attending the practice, a student would be unlikely to be involved in the consultation.

One practitioner also reported that student gender in relation to patient gender and the body part being treated were considerations when determining student involvement due to the potential need for a patient to undress within a consultation. As one male practitioner reported:

It does depend a little bit on the sex ratio. So a ... [woman] with two men in the room feels a bit uncomfortable. A ... [female patient] ... and a female student is much more comfortable. (P3)

Benefits of student placement.

Practitioners reported that the benefits of student placement were exposure to current physiotherapy teaching and the opportunity to develop educator skills. A practitioner also described the professional development value for staff in having to make explicit their clinical reasoning processes to a novice:

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Having them [the students] makes the practitioners make sure that they're right on their game. There is nothing like teaching something to make sure you know it yourself. (P1)

From a business perspective, the practitioners also reported the placement of students within their practices to be an excellent opportunity for an “extended interview” of potential new graduate employees. As one practitioner reported:

If they're good students, we could potentially employ them. (P3)

In the case of good students, one practice reported that student placement can provide additional treatment time for patients, where

They will often get 20 minutes of my time ... and then you'll go into the gym, and the student will supervise the exercises for another, you know, 20 minutes, half an hour. (P3)

This was not, however, common practice.

The practitioners also reported supporting undergraduate education from their altruistic belief that “*it's the right thing to do.*” (P4)

Challenges.

Despite all practitioners interviewed expressing commitment to undergraduate education, the challenges of educating in the private practice setting dominated participant discussion. The time and workload demands of teaching in this setting were raised by all participants:

You have a busy list to start with, and then you have to factor in, you know, your teaching time and be able to bounce stuff off the student while you've got the person there. (P2)

There was variation in the approach taken by interviewees to manage undergraduate teaching, with three practices continuing their usual caseload and one reducing its patient list during student periods to dedicate time to teaching. In this practice, the practitioner with the education portfolio dropped their caseload by 30% during student placements, with a corresponding reduction in practice income.

An additional challenge reported was insurance considerations, where students were seen as a liability, which further limited the amount practitioners permitted students to do:

Insurance-wise you can't leave them in charge of any patient by themselves. (P1)

Lack of teaching preparedness.

The practitioners reported a lack of knowledge about the current undergraduate curriculum and unanimously reported a lack of formal training in education skills. The participants were aware of these deficits and that professional development in clinical education skills was offered through the universities. The practitioners commented that professional development would be extremely useful in this domain:

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I have no formal training in teaching of any description and basically present things to them as I've learnt them or how I would learn them. So that may or may not be appropriate for that person or for that particular piece or area of knowledge. (P2)

The practitioners also commented that expectations of student skills need to be made clearer and a formalised plan or structure provided to support student placements:

Some feedback to us as to what you expect us to get through too would be good. (P2)

If you had a formalised program ... I'm sure you would find ... practices would be willing to take students. (P3)

A week-by-week breakdown of target skills was proposed, with a clear description of expected competencies by the end of the placement. Practitioners also wanted professional development that was brief and targeted. They suggested that written resources should be limited to succinct two-page summary guides and that an online education module may be useful.

Student knowledge and skill gaps.

Many “gaps” in student skills and knowledge were reported, which impacted on students’ readiness for private practice. Anatomy, pathology, the ability to conduct a thorough interview, assessment skills, patient handling, spinal treatment and exercise prescription were all cited as areas needing greater skill development. Some examples of the reported knowledge and deficits are reported below:

It's sometimes as simple as: where does this muscle come from and go to. Origins, insertions and what does it do. (P2)

A lot of them are doing hospital placements, so they don't even—they've never seen a shoulder. They've never seen a back sciatica, because they've seen total hips and knees. (P4)

Students’ difficulty completing time-efficient assessment routines and insufficient clinical reasoning and diagnosis were perceived as particularly important deficits that needed improvement:

I want ... [an assessment] ... routine that's acceptable. (P4)

Building the hypothesis, or the clinical probability, I think that's the big one. (P1)

Students were also reported to be ill-prepared for the private practice “realm of thinking” and the basics of how to fill in the required paperwork:

None of them have had any experience on that sort of thing. They have got no idea the paperwork involved, the billings, the answering of phones, dealing with clientele, ... how private health insurance runs, how WorkCover, TAC ... (P3)

Current placement practice.

Tutorials were delivered to students at all private practices at least weekly. Topics that were routinely covered in the tutorials included interviewing skills, assessments of shoulder, knee, ankle and back, and exercise progression. The tutorials served both as

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a teaching opportunity and a way for practitioners to ascertain students' knowledge and skills. Students at three of the four practices had limited autonomy and rarely undertook complete patient consultations; it was more likely that they would engage in a segment of the consultation conducted by the clinician. The skill of the student had a small impact on the extent of involvement they were afforded:

[The student] may take them through the testing. If it's a new patient with a 40-minute block, they can do a little bit more because I've got a little bit more time. If I've got a 20-minute block ... they'll get to run some of the assessment, and it's usually just reassessment because you have usually seen them already, and they get to do some treatment. They may get to teach ... exercises. They're the sort of the things I've identified I can handover ... and not fall too far behind time-wise. (P2)

Course restructure.

To address the reported student knowledge and skill deficits, the practitioners all suggested both a shift in undergraduate curriculum emphasis and increasing student exposure to private practice learning opportunities. Some believe a private practice placement should be compulsory for all students prior to graduation:

More people go into private practice, but they haven't done any private practice. (P3)

All thought that students should be assessed in this setting.

Other suggestions for improvement included a more comprehensive "transition into practice program" for graduates such as a "cadet" year for physiotherapy graduates to allow ongoing education and an opportunity to consolidate clinical skills under clinical supervision.

Discussion

These data help us better understand the views of both patients and private practitioners in considering pre-entry-level private practice opportunities for physiotherapists.

Participating patients and practitioners supported clinical education in the private practice environment. Patients' altruistic support of student learning in clinical practice was the main reason given for consent. Over 85% of private patients were "very comfortable" with students either observing or completing an interview in private practice; however, participating practitioners do not have a clear system in place for identifying this subset of patients. Although many patients are comfortable with student observation and assessment, private patients reported varying degrees of comfort with student involvement in their assessment, treatment, exercise prescription and group work. Most importantly, only 29% of patients reported being "very comfortable" with a student delivering treatment. Practitioners in this setting would, therefore, be advised to ensure that informed consent for student participation in a consultation is aligned with detailed individual patient preferences. Patients seeking treatment for their neck appear less comfortable with student care, and younger female patients may be less likely to consent to a student proposing and delivering their physiotherapy treatment

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(Table 2). For a small number of patients, the student's gender and the nature of the consultation may be a consideration affecting consent for student involvement. These issues have been previously reported in general practice settings (Choudhury et al., 2006; Sweeney et al., 2010).

There was a misconception by some practitioners that patients seen by students could not be billed, which was raised as a barrier by PBA in 2010. The Australian Physiotherapy Association's National Physiotherapy Service Descriptors (2012) states that "services provided by a physiotherapy student under the supervision of a physiotherapist are deemed a normal physiotherapy consultation on any given occasion of service, for the purposes of itemisation and coding, where all elements of a consultation are met, irrespective of the student involvement." As occurs in all areas of undergraduate physiotherapy education, the student is responsible for the completion of the task, but the physiotherapist oversees the care, may augment services provided by the student and retains accountability. However, as PBA also report, financial remuneration may still be reduced for private practitioners involved in clinical education if there is a reduction in the number of patients seen per session.

A finding consistent with previous health education literature was the need to better prepare practitioners for the teaching role (Kilminster & Jolly, 2000). The assumption that skilled clinicians will have sufficient education skills to facilitate an effective learning experience for undergraduate students cannot be made. Training in education principles, feedback delivery and assessment should be considered as part of the solution to increasing quality and capacity of undergraduate education in private settings. The practitioners also requested clearer expectations from university partners, a structure to facilitate a scaffolded student exposure to private practice and tailored professional development for practitioner educators. Strategies to reduce direct teaching time would be particularly useful. The current practice of different clinicians concurrently delivering individual tutorials on similar topics in the same geographical region would appear to be an inefficient use of private practitioner time and should be reconsidered. It could be argued that the delivery of this core curricular content could be provided more efficiently to the entire cohort at the university within a practical class prior to student placement or made available online for self-directed learning and revision. In consideration of this, greater input from private practitioners in reviewing the content of pre-entry curriculum should be explored.

Physiotherapy curriculum is designed to develop skills that meet workforce needs, and alignment requires regular input from the profession to remain current. Attention to "hands-on" skills, time-efficient physical assessment, diagnosis, clinical reasoning and the paperwork requirements of private settings were important learning targets specified by practitioners in this study. Regardless of the amount of preparation for practice that is provided in the pre-clinical years, effective workplace skills require further practice. The challenge for the future is to prepare students to a level where practitioners are

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willing to allow them to practise when on placement in private clinics. Practitioner educators will need to be recruited in this task so that implementation strategies meet their perceived needs.

A limitation of this study was the small sample of both patients and practitioners, with only four of the eight potential private practices participating; however, the practices most frequently involved in clinical education in the region were represented. It cannot be assumed that the views of these patients and practitioners are representative of all practices, particularly those with a specific area of expertise. These views also represent those of clinicians already engaged in clinical education but may not represent other clinicians. Patient survey distribution was not sequential due to the busy nature of participating practices and different operational preferences of reception staff within each practice. Furthermore, only those patients that elected to participate in the study completed the patient surveys. There may be a large group of patients with quite different views who declined participation in the survey. A study ascertaining patient perceptions directly after student participation in a consultation would be worthwhile, as many patients surveyed had not experienced student participation in their care, and therefore, opinions were speculative. Finally, future research investigating the economic and financial repercussions for private practitioners and universities of undergraduate private practice placements would also inform sustainability (Haines, Isles, Jones, & Jull, 2011).

Conclusion

For clinical education to better align with workforce practice, physiotherapy students need to be work-ready for private practice by graduation. Universities and the primary care sector need to continue to work together to develop appropriate preparatory material that serves the needs of all stakeholders. A subset of patients report being very comfortable with student provision of care, and these patients have the potential to offer ideal “hands-on” student practice opportunities. In addition, some patients would opt for student services if it were provided at a reduced rate. Other patients would prefer student engagement to be limited to observation and interviews only. A method for routinely identifying patient preferences regarding student service provision would assist in aligning patient preferences and student activities. Private practitioners need to ensure informed consent processes reflect this subtlety. There is also a need to better support practitioners within the private setting with a documented structure for student placements and education to equip clinicians with the skills required for teaching.

Acknowledgements

We thank Peninsula Health and Mornington Peninsula Clinical Placement Network for facilitating this project.

This project was possible due to funding made available by Health Workforce Australia and the Department of Health, Victoria.

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