



Research

Clinical placements in private practice for physiotherapy students are perceived as safe and beneficial for students, private practices and universities: a national mixed-methods study

Casey L Peiris ^a, Alan Reubenson ^b, Ruth Dunwoodie ^c, Vidya Lawton ^d, Alison Francis-Cracknell ^e, Cherie Wells ^f

^a School of Allied Health, Human Services and Sport, La Trobe University, Melbourne, Australia; ^b School of Allied Health, Curtin University, Perth, Australia; ^c School of Health and Rehabilitation Sciences, The University of Queensland, Brisbane, Australia; ^d Faculty of Medicine, Health and Human Sciences, Macquarie University, Sydney, Australia; ^e Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, Australia; ^f School of Allied Health, Exercise and Sports Science, Charles Sturt University, Port Macquarie, Australia

KEY WORDS

Physical therapy
Clinical education
Private practice
Mixed methods



ABSTRACT

Question: What are the extent and characteristics of clinical placements in private practice for physiotherapy students? What do university clinical education managers perceive to be the benefits, risks, barriers and enablers of clinical placements in private practice for physiotherapy students? What training and support are available for private practitioners? **Design:** Mixed methods study combining a national survey and in-depth, semi-structured focus group interviews. **Participants:** Twenty clinical education managers from Australian universities who had graduating students in entry-level physiotherapy programs in 2017 (95% response rate) responded to the survey with data on 2,000 students. Twelve clinical education managers participated in the focus groups. **Results:** It was found that 44% of physiotherapy graduates in Australia in 2017 completed a 5-week private practice placement. Private practice placement experiences were perceived to be safe and beneficial for students, private practices and universities. The main risks identified by clinical education managers were related to the quality and consistency of the student's experience on placement and not risks to service or clients. The main perceived barriers were time costs (both practitioner and university clinical education managers) and perceived lost earning capacity. Clinical education managers emphasised that more time and resources to establish and support private practitioners would enable them to reduce risk and overcome barriers to increasing private practice placement capacity and quality. Engaging private practitioners and working collaboratively appear vital for establishing, monitoring and supporting private practice placements. **Conclusion:** By working collaboratively, universities and private practice physiotherapists can enhance private practice placement capacity and quality. [Peiris CL, Reubenson A, Dunwoodie R, Lawton V, Francis-Cracknell A, Wells C (2022) Clinical placements in private practice for physiotherapy students are perceived as safe and beneficial for students, private practices and universities: a national mixed-methods study. *Journal of Physiotherapy* 68:61–68]

Crown Copyright © 2021 Published by Elsevier B.V. on behalf of Australian Physiotherapy Association. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Introduction

Clinical education in physiotherapy programs plays a critical role in ensuring that students develop and demonstrate clinical competence upon graduation.^{1–4} Clinical education typically involves clinical placements where students perform physiotherapy duties under the supervision of a qualified physiotherapist (clinical educator).^{1,4} Clinical placements in Australia occur in a range of clinical settings and areas so that students develop the competencies required to practise.⁵ A key aim of clinical placements is to prepare students for future work practice; therefore, clinical placement settings and learning opportunities should be guided by future workforce needs.⁶

Traditionally, most physiotherapy student placements are completed in hospitals. In 2012, it was estimated that only 5 to 10% of

physiotherapy students across Australia had undertaken a placement in private practice.⁷ This contrasts significantly with the proportion of physiotherapists working in private practice, which is reported to be between 43 and 60%.^{8,9} In addition, new graduates are increasingly being employed in the private sector, which includes both private practice and private hospitals.^{10,11}

Recent research indicates that new graduate physiotherapists in Australia may be underprepared for private practice employment.^{12,13} This has resulted in pressure from employers, graduates and professional bodies for universities to provide students with private practice placement experiences to increase preparedness.^{12–14}

Placement provision in health professional courses is a challenge internationally^{15–17} and the private sector appears to be underutilised in supporting student experiential learning.¹⁸ Previous placement

capacity building strategies have been proposed mostly in hospital settings. One popular approach is the student-led placement model, which Nicole and colleagues¹⁹ demonstrated increased student placement capacity by 213% in a previously underserved aged-care setting. However, the student-led model may not be feasible in an Australian private practice context due to restrictions on billing practices for student-provided services.²⁰ In another model, university academics provided onsite support to effectively increase placement capacity when six or more students were at one site;¹⁷ this may not be feasible in private practice, where space has been reported as a barrier to hosting multiple students.^{21,22} Therefore, strategies to increase the capacity of private practices to provide student placements are largely unknown.

University clinical education managers (CEMs) have a wealth of knowledge related to student placements in the context of the Australian and New Zealand Physiotherapy Practice Thresholds,²³ which describe the threshold competence required for initial and continuing registration as a physiotherapist in both countries. Although the specific duties may vary between universities, CEMs provide support for students and clinical educators to ensure that students' clinical education requirements are met. A CEM's role may include sourcing and allocating placements, providing training and support for clinical educators, supporting students, analysing and responding to feedback, and initiating and maintaining partnership relationships. CEMs are therefore well positioned to provide valuable insight into private practice placements in physiotherapy and potential benefits, risks, barriers and enablers to increasing placement capacity.

One aim of this study was to establish the current status of private practice placements in Australia (ie, placement numbers). Another aim was to explore the perspectives and experiences of university CEMs in Australia regarding physiotherapy private practice placement models, benefits/risks of providing clinical placements within private practice, training/support opportunities available to private practitioners, and barriers and enablers that impact the sourcing and maintaining of private practice placements.

Therefore, the specific research questions for this mixed-methods study were:

1. What are the extent and characteristics of clinical placements in private practice for physiotherapy students?
2. What do university clinical education managers perceive to be the benefits, risks, barriers and enablers of clinical placements in private practice for physiotherapy students?
3. What training and support are available for private practitioners?

Method

Design

This mixed methods study combined a national survey and in-depth, semi-structured focus group interviews. This design was chosen to enable data triangulation, as the survey provided raw data on private practice placements, whilst the interviews explored the experiences of CEMs in relation to these placements. Each university's human research ethics committee approval was obtained from leading and partner institutions of all authors prior to commencement of the study.

Participants

CEMs from all Australian universities who had graduating students in entry-level physiotherapy programs (Bachelor, Masters or Doctoral) in 2017 ($n = 21$) were identified from the Clinical Educator Managers Australia and New Zealand (CEMANZ) committee contact list. CEMs were contacted via email, with information and a hyperlink to participate in an online survey. Participants provided informed consent to participate within the survey. Purposive sampling was used to recruit participants for focus group interviews to ensure representation

from all states/territories with physiotherapy programs, as well as a mix of metropolitan and rural universities. Focus group interviews were conducted until data saturation was achieved (defined by the acquisition of no new themes or data being identified with further interviews).²⁴

Data collection

Data were collected through an online, self-administered survey using commercial software^a. The survey question used a combination of Likert scale, multiple-choice and open-ended questions. The survey was pilot tested by two CEMs and took approximately 20 minutes to complete. These CEMs provided feedback to the researchers on readability, structure and appropriateness of survey questions, and amendments were made prior to distribution.

The final survey sourced information on: student and placement numbers; placement setting and length; placement models; training and support for private practitioners; and benefits, risks, barriers and enablers of private practice placements. In relation to placement models, student to clinical educator ratios and three broad categories of placement models were considered: students providing consultation under supervision (student-led); student sharing consultations with physiotherapist (shared-care); or student observing consultations provided by physiotherapist (observational). For the purpose of this research, adverse events were defined as events reported to the university that occurred on placement resulting in harm to the student, patient or educator (eg, patient fall, patient complaint or student injury).

Semi-structured focus group interviews were conducted via teleconference calls to enable CEMs from diverse geographical locations to participate. Focus groups were chosen to explore CEM experiences, as they enable participants to explore and clarify their views and can help generate new ideas or remind participants of similar or different experiences.²⁵ All focus groups were facilitated by the same researcher (CW) who followed a flexible interview schedule (Table 1). Interviews were audio recorded and transcribed verbatim.

Data analysis

For survey response rates, demographics and closed survey questions, descriptive statistics were calculated using commercial statistical software^b. For focus group interviews, data collection and data analysis occurred simultaneously to check for data saturation.²⁴ Thematic analysis²⁶ was undertaken using commercial software^c to manage qualitative data. Two researchers (CW, CP) independently read transcripts for open and selective coding of the data, using an approach derived from grounded theory.²⁵ Researchers individually examined data and assigned codes (eg, risks, benefits, enablers) to portions of text and then looked for interactions and links between codes. Researchers CW and CP met to discuss and resolve differences. Next, they collaborated to decide on main themes and then selectively searched for further data on those themes (selective coding). Themes were sent to participants for member checking to ensure that the researchers' interpretations were accurate.²⁵ After feedback, researchers met to decide on final themes and relationships between themes. Survey and focus group data were analysed separately, and the identified themes and results were compared and contrasted (triangulated) for overall synthesis.²⁷

As researchers bring their own experiences into qualitative research and data interpretation, the researchers' backgrounds are briefly described here to enhance reflexivity. All researchers have qualifications in physiotherapy and were either current or former university CEMs. Four researchers had previously worked in private practice (CP, VL, AR, CW) and two had a PhD qualification (CP, CW).

Results

Participants

Survey

CEMs from all 21 of the eligible physiotherapy courses in Australia were invited to participate. Of these, 20 out of 21 physiotherapy

Table 1
Flexible interview schedule.

Aim	Sample questions and prompts
Explore private practice clinical placement experiences across the country	Can you describe the private practice clinical experiences of the students at your university? Prompts: • What type of placement (core/elective/introductory) and when do students experience it? • Is it same/different to other settings? (hours, expectations)
Explore the perceived benefits of private practice placements	What do you think are the benefits of private practice placements for physiotherapy students? Prompts: • Benefits for student, clinical educator, practice, university
Explore any risks associated with students undertaking placements in private practice	Can you share any risks associated with students undertaking placements in private practice? Prompts: • Risks for client, student, practice • How these compare to other settings
Explore barriers to sourcing and securing private practice placements	What are the major barriers of sourcing and securing private practice placements for physiotherapy students? Prompts: • Differences to other settings, practice needs, resources
Explore enablers to sourcing and securing private practice placements	What are the major factors that can assist you in sourcing and securing private practice placements for physiotherapy students? Prompts: • Differences to other settings, practice needs, resources
Explore private practice clinical placement models	Describe the private practice clinical placement models that private practices provide to your students. Prompts: • Consultations: number and type of clients, shared/separate, fees • Clinical and non-clinical skills • Supervisions: ratios, direct/indirect
Explore training and support offered to clinical educators/private practices	Describe the training and support that universities currently provide. Prompts: • Online versus face-to-face; content and duration of training; contact with clinical education coordinator/manager; payment • Strengths and limitations of current training and support provided and how can this be improved?
Check if anything has been missed	Do you have any final comments regarding private practice experiences for physiotherapy students in entry-level programs within Australia and suggestions for improvement? Prompts: • Priorities, next steps, stakeholder roles

programs participated, giving a 95% response rate to the survey. [Table 2](#) describes the characteristics of the survey participants. These respondents from 20 universities were able to provide data on 2,000 students ([Table 3](#)), including detailed data on the 2017 cohort of student placements. The survey also obtained data on the nature of the clinical placements ([Table 4](#)) and the training and support given by the universities to the private practitioners ([Table 5](#)).

Focus groups

Twelve CEMs (including representation from all states and territories) participated in focus group interviews. [Table 6](#) describes the characteristics of the participants in the focus groups. Three focus group interviews were conducted before data saturation was achieved, with no new themes emerging from the final focus group (n = 4 participants).

Theme 1: Private practice placements are increasing, but more are needed

There's a huge demand (P12)

Placement data for the 2017 graduating cohort were provided by 18 universities (n = 1,471 students). All universities sourced private practice placements, which predominantly occurred in the final year of study. It was found that 44% of students (n = 643 of 1,471) completed a 5-week private practice placement ([Table 3](#)). Considering that students complete more than one placement each, 9% of all clinical placements undertaken were in private practice ([Figure 1](#)).

Qualitative data confirms that CEMs have increased their efforts to source clinical placements in private practice, but a mismatch remains between demand and supply of placements in this setting.

We don't have the numbers of placement offers to allocate to every student (P12)

Theme 2: Training and support are offered, but engagement is low

We rarely get private practitioners coming (to training) (P11)

All universities provided training on how to assess students using the Assessment of Physiotherapy Practice (APP) tool, as well as individual phone, email and/or face-to-face support. Most universities also provide other training opportunities ([Table 5](#)). However, CEMs conceded that private practitioner attendance is low (online or face-to-face).

They can't free up the time to access the training and that's a bit of a barrier (P9)

CEMs reported that lack of engagement in training was a barrier to increasing capacity and adversely affected quality and consistency.

There are wide variations in the quality of education provided and the assessments of students. This can be due to lack of engagement with unis (P5)

Where educators were engaged with universities and there was regular, two-way communication and collaboration, quality was enhanced.

We have a host of about ten private practices that are really great supporters of our program and that we know run a good model (P2)

Theme 3: A combination of placement models is used

I don't think there is a model that works for everyone (P10)

CEMs reported that private practices often opted to use a combination of models (student-led, shared-care and observational) depending on student stage of learning, as well as patient and business needs. In the combination model, CEMs reported that students typically commenced by observing their educator (estimated at 29% of the placement, SD 16), then progressed to shared-care consults (34%, SD 14) and finally to student-led care (41%, SD 29). A variety of supervision ratios were employed by private practices, with no particular preference noted ([Table 4](#)). Observation of educator consults was perceived to be a valuable part of a student placement, but not appropriate for an entire placement if the student was assessed with the APP. CEMs perceived there was no one placement model that would suit all practices and reported working with practices to individually tailor models.

In the context of meeting learning objectives... observation only is not something that we can usually entertain... There has to be some

Table 2
Characteristics of survey participants.

Characteristic	Participants (n = 20)
Sex, n (%)	
female	18 (90)
male	2 (10)
State, n (%)	
New South Wales/Australian Capital Territory	6 (30)
South Australia	2 (10)
Queensland	6 (30)
Victoria	4 (20)
Western Australia	2 (10)
Experience in physiotherapy (yr), mean (SD)	22 (8)
Experience in clinical education management (yr), mean (SD)	6 (5)

kind of commitment to a shared kind of interaction and hands-on opportunity. But we do have a range of options (P12)

Theme 4: Private practice placements are beneficial and low risk

The benefits are great; risk is very, very low (P3)

Most survey participants agreed with several benefits of private practice placements (Figure 2), which were elaborated on convergently in focus groups. CEMs perceived that private practice placements helped increase student employability for this sector through orientation to private practice, managing patient expectations and running a business.

It's very beneficial for the students, in terms of their employability (P2)

CEMs also perceived benefits for private practices (eg, screening student suitability for future employment, extending patient services with student assistance, and enhancing practice credibility by supervising students and partnering with universities) and clinical educators (eg, improved clinical reasoning, critical reflection, research informed decision-making, and access to library resources and professional development).

There's another buy in for our practitioners, they're looking to diversify their experience and their skills... (P2)

The risk of adverse events occurring during a private practice placement was perceived to be low, as students are supervised during client consults and are academically competent before commencing placement. Quantitative data supported this assumption, with no major adverse events being reported. One minor adverse event was reported by a CEM, where a patient experienced temporary discomfort due to incorrect use of electrotherapy by a student.

The main risk perceived by CEMs was inconsistent quality of private practice experiences. CEMs perceived that some students may not get enough 'hands-on' practice and that private practitioners were limited for time, impairing their ability to provide adequate supervision, facilitate clinical reasoning and provide feedback (which were identified as barriers by survey participants) (Figure 2).

It's the quality side of things; you just don't know what's happening out there as well as we do know in the big hospitals (P9)

Theme 5: Private practice placements cost time and money

It goes both ways (P9)

Lack of time to supervise students was perceived to be a barrier for private practices providing placements (Figure 2). If an educator

Table 3
Characteristics of students at participating universities.

Characteristic	Students (n = 2,000)
Students (<i>n per university</i>), range	30 to 270
Enrolled degrees, n (%)	
Bachelor with/without honours	1,186 (59)
combined Bachelor and Masters	130 (7)
graduate entry Masters	466 (23)
extended Masters	108 (5)
Doctorate	110 (6)
Detailed placement data from 2017 cohort of 18 universities	(n = 1,471)
Students (<i>n per university</i>), range	17 to 173
Enrolled degrees, n (%)	
Bachelor	452 (31)
Bachelor with honours	379 (26)
combined Bachelor and Masters	219 (15)
graduate entry Masters	221 (15)
extended Masters	100 (7)
Doctorate	100 (7)
5-week clinical placements per student (<i>n</i>), mean (range)	6 (4 to 8)
Placement hours per student, mean (SD)	999 (124)
Placements for this cohort (<i>n</i>), total	8,792
Students who had a private practice placement, n (%)	643 (44)

Some percentages do not sum to 100 due to the effects of rounding.

had insufficient time to support students, the quality of student experience may also have been affected.

Time is probably the biggest thing for a practice... [they] will often end up just saying just watch me because I can't afford to take the time away from my patient (P1)

The time needed to supervise students was also perceived to potentially reduce a practitioner's caseload (and therefore earning capacity), especially when students were underperforming.

It often takes a bit more time from the practitioner [to supervise] and potentially a risk for the practice because of lost earning capacity [especially] when that supervisor's spending more time with the weaker student (P10)

Perceived lost earning capacity for educators was also reported to result from not being able to bill for some third-party funded services if a student was involved in patient care, charging less for student consults or providing longer consults at the usual rate. However, it was proposed that cost savings would be made later in placements

Table 4
Characteristics of universities and their private practice placements.

Characteristic	Universities (n = 20)
Degrees offered, n (%) ^a	
Bachelor	10 (50)
Bachelor with honours	12 (60)
combined Bachelor and Masters	2 (10)
graduate entry Masters	7 (35)
extended Masters	2 (10)
Doctorate	1 (5)
Universities collaborating with specific types of private practice, n (%)	
majority single private practices	10 (50)
majority group/multi-site private practices	2 (10)
mixture of single and group private practices	8 (40)
Universities' expected clientele at collaborating private practices, n (%) ^a	
majority musculoskeletal	20 (100)
significant component of sports	10 (50)
includes paediatrics, aged care and/or gender health	7 (35)
Universities' typical ratio used at collaborating private practices, n (%)	
1 clinical educator : 1 student	10 (50)
2 clinical educators : 1 student	6 (30)
1 clinical educator : 2 to 5 students	4 (20)

^a More than one response could be selected.

Table 5
Universities offering training and support to private practitioners.

Type of training or support, n (%)	Universities (n = 20)
Assessment of Physiotherapy Practice (APP) tool	20 (100)
Individual phone, email and/or face-to-face support	20 (100)
Face-to face introductory clinical educator training	19 (95)
Effective supervision and support training	18 (90)
Professional development opportunities not related to clinical education	17 (85)
Supporting students at risk of failing	13 (65)
Financial contributions	13 (65)
University affiliation including library access	13 (65)

(when students reached entry-level competency) and by attracting graduates, thus reducing recruitment costs.

CEMs felt that where it occurred, remuneration from universities provided some contribution to offset reported costs incurred by private practices. Other non-monetary benefits (eg, library resources, university training) were proposed by CEMs as welcomed value-adding incentives.

The remuneration is generally pretty small and won't necessarily recoup the cost of taking the student in the first place. So the benefits are much grander and much more sort of forward thinking than just saying oh well we get money for it (P11)

CEMs also noted significant time and costs incurred by universities in providing training and support for private practices to host small numbers of students.

Establishing, building, maintaining relationships and quality assurance just takes a whole lot longer because you've just got more partners... And so you have to do the same thing multiple times... Whereas, you know, major public hospitals where you've got one phone call or one email and you deal with everything in one go for a hundred students (P10)

Theme 6: Enhancing engagement to increase capacity and quality

It is built on coffee and trust (P2)

Positive relationships and engagement were commonly reported by CEMs as being essential to developing quality private practice experiences and were identified as integral to establishing, monitoring and supporting private practice placements.

It's our relationships that build these clinical placements and I often say, like clinical education is kind of built on coffee and trust (P2)

CEMs suggested that an increase in placement capacity may be assisted by having additional time and resources to recruit, train and support private practice providers. CEMs reported that when practices are positively engaged with the university by regularly taking students, participating in training and communicating with university staff, placement quality is enhanced.

(Some) placements are stand out excellent you know. The investment that the team in private practices are prepared to put into clinical education really does stand out (P3)

There were also perceptions that private practices who weren't engaged were less equipped to manage poor-performing students, and negative experiences may result in fewer placements being provided.

They can't cope with anyone deemed to be difficult... they find it really hard to know what to do and they will go 'oh we're not having another one' (P4)

Table 6
Characteristics of the focus group participants.

Characteristic	Participants (n = 12)
Sex, n (%)	
female	11 (92)
male	1 (8)
State, n (%)	
New South Wales/Australian Capital Territory	4 (33)
South Australia	2 (17)
Queensland	4 (33)
Victoria	1 (8)
Western Australia	1 (8)
Experience in physiotherapy (yr), mean (SD)	24 (10)
Experience in clinical education management (yr), mean (SD)	8 (6)

Some percentages do not sum to 100 due to the effects of rounding.

CEMs felt that engagement and timely communication prevented this situation.

I hear at the end of the placement, oh we had all these troubles... like why didn't you call me? And they didn't know who to call... Whereas other practices as soon as there's a problem, they're on the phone, it's all sorted within a day (P9)

Discussion

This mixed methods study determined that 44% of final year physiotherapy students in Australia in 2017 completed a 5-week private practice placement. Private practice placement experiences were perceived to be safe and beneficial for students, private practices and universities. The main risks identified by CEMs were related to the quality and consistency of student experience on placement and not risks to clients. CEMs perceived that the main barrier to hosting students for private practitioners was time costs incurred by the private practice and/or clinical educator. CEMs emphasised that more time and resources to establish and support private practitioners would enable them to enhance engagement and increase private practice placement capacity. A variety of successful placement models were identified as currently being used in private practice. The adopted models were influenced by contextual factors relating to the practice, stage of learner and university requirements, highlighting the need for flexibility to optimise and increase placement capacity. Although CEMs reported that universities offer a variety of supports to private practices, it was conceded that training was not well attended by private practitioners, and this may impact ongoing supply and quality of placements. Working collaboratively to better understand the needs of both the universities and private practices related to training and support appears vital for enhancing engagement and establishing quality, sustainable experiences for students.

Universities and private practices have worked together to increase the number of private practice placement experiences nationally more than fourfold since 2012.⁷ CEMs identified that private practice placements were safe learning environments that enhance student experience and new graduate readiness, which has also been

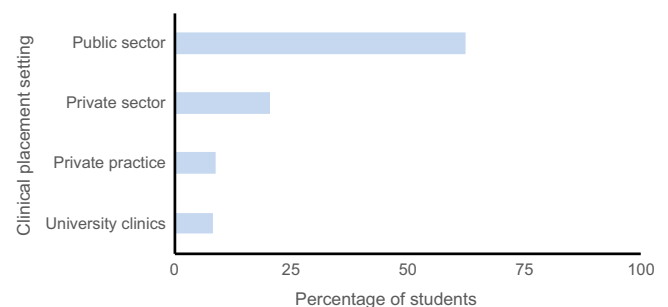


Figure 1. Percentage of physiotherapy students attending clinical placements in specific sectors of the profession.

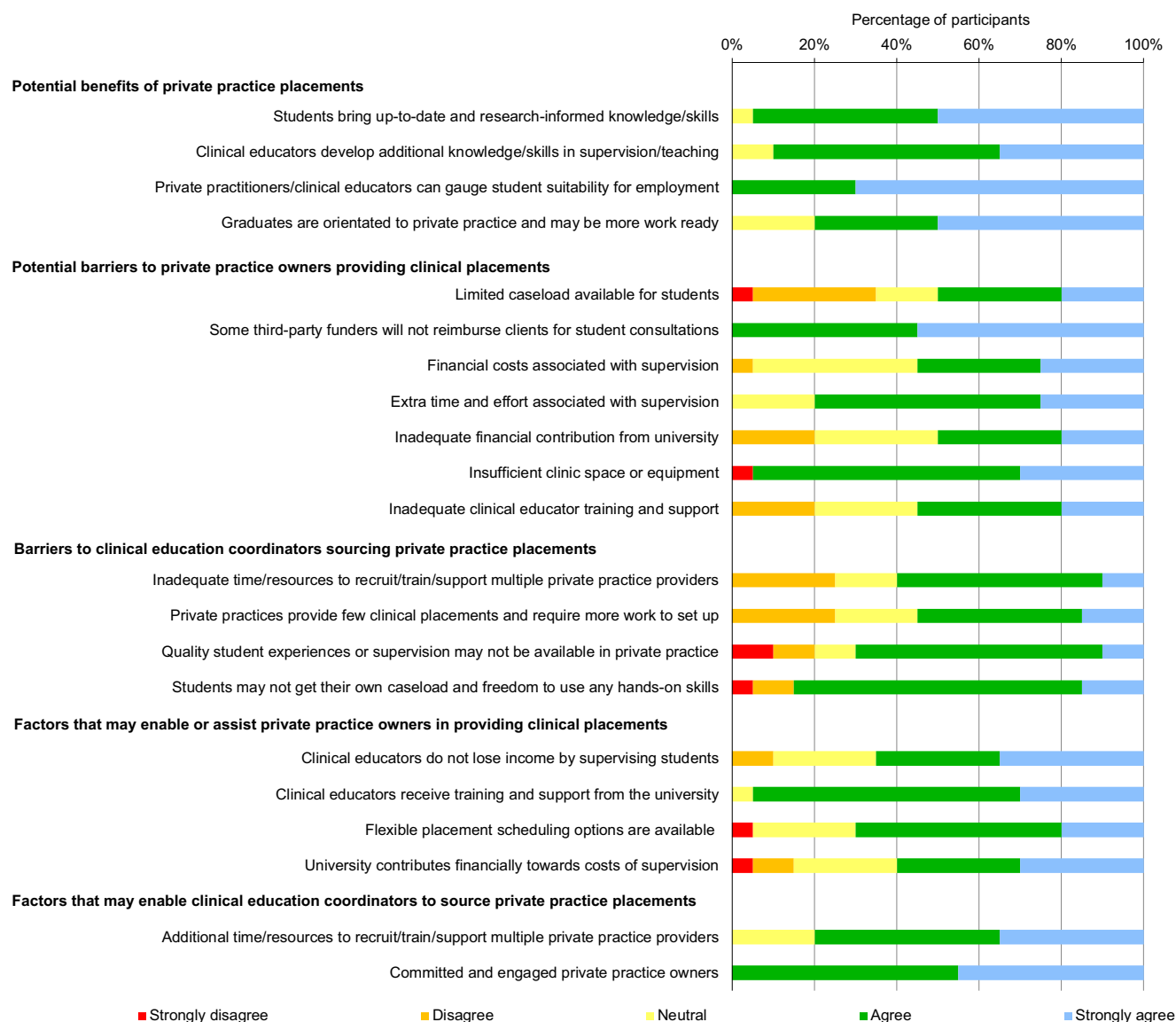


Figure 2. Percentage of participants reporting each category of agreement with statements in the survey.

recognised by private practitioners.^{12,22} However, benefits for placement providers are traditionally more difficult to define, especially considering that service provision benefits are limited by funding arrangements in private practice. CEMs in this research identified a broad range of benefits that may be under-recognised, such as future workforce recruitment and selection, continuing professional development opportunities, clinical educator training and university affiliation (eg, access to libraries, on-line resources, research mentors and academic expertise; potential adjunct status). Some of these benefits have recently been recognised by private practitioners²¹ and have been identified as being vital in attracting the provision of placements.^{28,29} Many parties benefit from private practice placements for physiotherapy students and the positives for placement providers need to be optimised and emphasised to enhance placement capacity.

Despite the benefits, perceived costs of clinical education may be an ongoing issue in private practice. CEMs indicated that costs reported by private practices were predominantly time costs and potential lost productivity (particularly for underperforming students), which is supported by Maloney et al.³⁰ Potential for lost income may be a barrier to hosting students in private practice; however, it is unclear which model of placement provision would best address this barrier, and this may vary in different practice contexts. Anecdotally there is a perception that funds received by universities should be passed on to placement providers to cover costs. However, an analysis

of Australian universities found that the cost of running university health courses with clinical placements exceeded the funding received for these courses.³¹ This suggests that financial incentives alone may not be a sustainable option and that other non-financial incentives should be explored to add value to practices so that hosting students is more attractive.

The results indicate that financial and non-financial contributions by universities along with goodwill and engagement are necessary for private practice placement viability. Goodwill, together with an effective model and culture of education have been long present in the public sector, reflected in the fact that 81% of all health placements are in the public sector.²⁹ For physiotherapists in public health, clinical education is a role expectation.³⁰ To provide placement opportunities, private practitioners may require more motivation than public health physiotherapists, in order to balance the time needed to educate students with business priorities.¹⁸ CEMs report working with a number of excellent private practices who provide effective clinical education experiences, but this research did not identify any one model of education that was deemed most effective in private practice. This is not unexpected, as there are many considerations and unique attributes of individual private practices. However, underpinning the success of any model is universities and private practitioners working collaboratively through engagement and communication, including appropriate training and support, leading to a perceived enhanced quality experience for all

parties. Indeed, private practitioners reported that support from universities is key to resolving challenges when hosting students, and those who reported close and supportive relationships with universities perceived that challenges were easily overcome.³² Collaboration and engagement are essential for developing placement models that support learning objectives for students while maintaining business objectives.

Clinical educator preparation is key to successful clinical placements and clinical expertise alone does not necessarily translate into clinical educator expertise.¹⁶ A need to better prepare private practitioners to be clinical educators has previously been identified;¹⁴ however, despite training being available, CEMs reported low attendance by private practitioners. Similarly, Maloney et al.³⁰ reported that hospital clinical educators were more likely to want to attend training than clinical educators in private practice. Engagement in training and support offered by universities can strengthen relationships and communication, support the management of under-performing students, enhance clinical educator access to other non-financial benefits and university resources, provide clinical educators with professional development, and improve placement consistency and quality. Therefore, it is important that universities and private practices collaborate to provide training that is accessible and supports participation without detracting from other business priorities. National collaboration among universities when developing training resources would distribute the load, reduce cost and improve consistency of support provided.

This research was focused on Australian entry-level physiotherapy student placements, so the results may not be representative of student placement experiences internationally. The research only presents the views of university CEMs, and further research is required to balance this research with views of private practitioners. However, this research did include CEMs from almost all physiotherapy programs in Australia, thus providing rich and robust data. Future research should also explore successful models of private practice placements to help guide CEMs and private practitioners to set up new placement experiences.

In conclusion, this research found that more Australian physiotherapy students are being exposed to private practice than previously reported. Private practice placements were perceived to be safe and beneficial, but had time and financial implications for both practices and universities. Modifiable risks and barriers related to the variable quality of educational experiences were identified. Universities and private practice physiotherapists have a shared responsibility to shape the future workforce, and by working collaboratively they can enhance private practice placement capacity and quality.

What was already known on this topic: Clinical placements prepare physiotherapy students for future work practice, so clinical placement settings and learning opportunities should match future work contexts. Despite this, most physiotherapy student placements are completed in public hospitals.

What this study adds: More Australian physiotherapy students are undertaking clinical placements in private practice than previously reported. Private practice placements were perceived to be safe and beneficial but had time and financial implications for both practices and universities. The main risks perceived related to the variable quality of educational experiences. Engaging private practitioners and working collaboratively foster private practice placements.

Footnotes: ^a SurveyMonkey software, SurveyMonkey, Palo Alto, USA.

^b SPSS Windows Version 24, SPSS, Chicago, USA.

^c NVivo 12 software, QSR International Pty Ltd.

Ethics approval: The study was approved by ethics committees at The University of Queensland, La Trobe University, Curtin University, Macquarie University, Monash University and Charles Sturt

University. All participants gave written informed consent before data collection began.

Competing interests: The authors have no conflicts of interest to declare.

Source(s) of support: Nil.

Acknowledgements: We acknowledge the La Trobe University Social Research Assistance Platform for providing research support for interview transcription. We would also like to acknowledge Cambridge McCormick and Alexis Nicholson for their assistance in organising focus groups and transcribing interviews.

Provenance: Not invited. Peer reviewed.

Correspondence: Casey L Peiris, Discipline of Physiotherapy, School of Allied Health, Human Services and Sport, La Trobe University, Melbourne, Australia. Email: C.Peiris@latrobe.edu.au

References

- Baldry Currens J. The 2:1 clinical placement model. *Physiotherapy*. 2003;78:540–554.
- Stiller K, Lynch E, Phillips AC, Lambert P. Clinical education of physiotherapy students in Australia: Perceptions of current models. *Aust J Physiother*. 2004;50:243–247.
- Dalton M, Davidson M, Keating J. The Assessment of Physiotherapy Practice (APP) is a valid measure of professional competency of physiotherapy students: A cross sectional study with Rasch analysis. *J Physiother*. 2011;57:239–246.
- Patton N, Higgs J, Smith M. Clinical learning spaces: Crucibles for practice development in physiotherapy clinical education. *Physiother Theory Pract*. 2018;34:589–599.
- Physiotherapy Board of Australia. Physiotherapy Board of New Zealand. Physiotherapy practice thresholds in Australia and Aotearoa New Zealand. Australian Physiotherapy Council; 2015. <https://physiocouncil.com.au/media/1020/physiotherapy-board-physiotherapy-practice-thresholds-in-australia-and-aotearoa-new-zealand-6.pdf>. Accessed July 22, 2018.
- Bacopanos E, Edgar S. Employment patterns of Notre Dame graduate physiotherapists 2006–12: targeting areas of workforce need. *Aust Health Rev*. 2016;40:188–193.
- Health Workforce Australia. Clinical training profile: Physiotherapy. Adelaide: Health Workforce Australia; 2014. <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiR0eHFueXsAhX8wjgGHTQSD5kQFjAAegQIAxAc&url=https%3A%2F%2Fadhs.edu.au%2Fwp-content%2Fuploads%2F2018%2F05%2Fclinical-training-profiles-project-physiotherapy.pdf&usg=AOvVaw1vEZsfADvXduocDhRWrxY>. Accessed November 3, 2020.
- National Health Workforce. Data Set (NHWDS) Factsheet: Physiotherapists; 2017. <https://hwd.health.gov.au/publications.html#alliedh17>. Accessed 3 November, 2020.
- Pretorius A, Karunaratne N, Fehring S. Australian physiotherapy workforce at a glance: a narrative review. *Aust Health Rev*. 2016;40:438–442.
- Health Workforce Australia. Australia's health workforce series – Physiotherapists in focus. Adelaide: Health Workforce Australia; 2014. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwj9tdeHveXsAhXXxzgGHVWY6CXMQFjAAegQIAxAc&url=http%3A%2F%2Fiaha.com.au%2Fwp-content%2Fuploads%2F2014%2F03%2FHWA_Australia-Health-Workforce-Series_Physiotherapists-in-focus_vF_LR.pdf&usg=AOvVaw2TlvpvHkgK3-8gkplzo0jts. Accessed July 22, 2018.
- Mulcahy A, Jones S, Strauss G, Cooper I. The impact of recent physical therapy graduates in the workforce: A study of Curtin University entry-level physiotherapists 2000–2004. *Aust Health Rev*. 2010;34:252–259.
- Atkinson R, McElroy T. Preparedness for physical therapy in private practice: Novices identify key factors in an interpretive description study. *Man Ther*. 2016;22:116–121.
- Davies JM, Edgar S, Debenham JA. A qualitative exploration of the factors influencing the job satisfaction and career development of physiotherapists in private practice. *Man Ther*. 2016;25:56–61.
- Kent FM, Richards KL, Haines TP, Morgan PE, Maloney SR, Keating JL. Patient and practitioner perceptions of student participation in private practice consultations: A mixed-methods study. *FoHPE*. 2015;16:42–54.
- Smith PM, Corso LM, Cobb N. The perennial struggle to find clinical placement opportunities: A Canadian national survey. *Nurs Educ Today*. 2010;30:798–803.
- Rodger S, Webb G, Devitt L, Gilbert J, Wrightson P, McMeeken J. A clinical education and practice placements in the allied health professions: an international perspective. *J Allied Health*. 2008;37:53–62.
- Fairbrother M, Nicole M, Blackford J, Nagarajan SV, McAllister L. A new model of clinical education to increase student placement availability: the capacity development facilitator model. *Asia-Pac J Coop Educ*. 2016;17:45–59.
- Doubt L, Paterson M, O'Riordan A. Clinical education in private practice: An interdisciplinary project. *J Allied Health*. 2004;33:47–50.
- Nicole M, Fairbrother M, Nagarajan SV, Blackford J, Sheepway L, Penman M, et al. Student-led services in a hospital aged care temporary stay unit: Sustaining student placement capacity and physiotherapy service provisions. *Asia-Pac J Coop Educ*. 2015;16:327–342.
- Australian Physiotherapy Association. FAQs: physiotherapy student placements in private practice; 2018. <https://australian.physio/student-placements-faqs>. Accessed June 18, 2020.
- Forbes R, Dinsdale A, Dunwoodie R, Birch S, Brauer S. Weighing up the benefits and challenges of hosting physiotherapy student placements in private practice: a qualitative exploration. *Physiother Theory Pract*. 2020;27:1–11.
- Wells C, Olson R, Kent F, Bialocerkowski A, Chipchase L, Scarvell J, et al. Are new graduate physiotherapists ready for private practice? Paper presented at the APA Momentum 2017 Physiotherapy Conference, Sydney. 2017.

23. Physiotherapy Board of Australia & Physiotherapy Board of New Zealand 2015. Physiotherapy practice thresholds in Australia and Aotearoa New Zealand. <https://www.physiotherapyboard.gov.au>. September 16, 2020.
24. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant*. 2018;52:1893–1907.
25. Liangputtong P. *Qualitative research methods*. 3rd ed. Hong Kong: Oxford University Press; 2009.
26. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3:77–101.
27. Thurmond VA. The point of triangulation. *J Nurs Scholarsh*. 2001;33:253–258.
28. Bowles K, Haines T, Molloy E, Maloney S, Kent F, Sevenhuysen S, et al. The costs and benefits of providing undergraduate student clinical placements for a health service organisation: An Evidence Check rapid review brokered by the Sax Institute for the Hunter and Coast Interdisciplinary Training Network through the Health Education Training Institute (HETI); December 2014. <http://www.heti.nsw.gov.au>. Accessed June 18, 2020.
29. Buchanan J, Jenkins S, Scott L. Student clinical education in Australia: an University of Sydney scoping study. Sydney: The University of Sydney; 2014.
30. Maloney P, Stagnitti K, Schoo A. Barriers and enablers to clinical fieldwork education in rural public and private allied health practice. *Higher Edu Res Dev*. 2013;32:420–436.
31. Deloitte Access Economics. Higher education teaching and learning costs. 2011. Canberra.
32. Forbes R, Dinsdale A, Dunwoodie R, Birch S, Brauer S. Exploring strategies used by physiotherapy private practices in hosting student clinical placements. *Aust J Clin Educ*. 2020;7.