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Juggling roles and generating solutions; practice-based educators' perceptions of performance-based assessment of physiotherapy students

A. O'Connor [a,b,*], P. Cantillon [c], M. Parker [d], A. McCurtin [a,b]

[a] School of Allied Health, Health Sciences Building, University of Limerick, Castletroy, Limerick V94 T9PX, Ireland
[b] Health Research Institute, University of Limerick, Castletroy, Limerick V94 T9PX, Ireland
[c] Discipline of General Practice, Clinical Science Institute, National University of Ireland, Galway H91 TK33, Ireland
[d] Department of Physical Education and Sports Sciences, University of Limerick, Castletroy, Limerick V94 T9PX, Ireland

Abstract

Objectives Physiotherapy lacks the significant body of evidence that underpins performance-based assessments in disciplines such as medicine and nursing. In particular, very few studies have examined stakeholder perspectives of the process. This study set out to explore the perceptions of clinicians who undertake student assessment in the workplace in order to inform further development of performance-based assessment in physiotherapy.

Design A qualitative, descriptive design was employed where focus group interviews were utilised for data collection. Inductive thematic analysis was used to analyse the data.

Participants Clinical educator and practice tutor volunteers affiliated with three Irish universities participated in one of seven focus groups ($n = 46$).

Results Two themes were identified; 1) Tensions in the clinical learning environment, 2) An optimal PBA process. The first theme describes clinical educators' struggle with juggling multiple roles and highlights the challenges of sustaining a balance between student mentoring and patient care. The second theme outlines factors perceived to contribute to an optimal performance-based assessment process; these include maintaining aspects of the current process and expanding the employment of dedicated educational roles in the workplace.

Conclusion Our findings illustrate a complex working environment for clinicians involved in student supervision and assessment. A dedicated educational role was perceived to provide a more standardised and rigorous approach to performance-based assessment. These findings provide critical stakeholder-centred insights, which may inform development of this process by addressing critical aspects deemed to facilitate and challenge clinical educator's roles as assessors.

Keywords: Performance-based assessment; Physiotherapy; Student; Clinical educator; Clinical education

Introduction

The goodwill of clinical educators cannot be underestimated in the professional education of physiotherapy students [1–4]. Clinical educators are qualified physiotherapists primarily involved in service provision in the clinical workplace, who undertake student supervision and assessment periodically and on a voluntary basis. Not only is there a critical reliance by universities on these clinicians for providing student education but also on their role in assessing students' readiness for independent practice. This assessment process, known as performance-based assessment (PBA), has several similarities within the discipline of physiotherapy globally [5,6], and has far-reaching implications includ-

* Corresponding author at: Department of Clinical Therapies, Health Sciences Building, University of Limerick, Limerick, Ireland.
E-mail addresses: Anne.OConnor@ul.ie (A. O'Connor), Peter.Cantillon@nuigalway.ie (P. Cantillon), Missy.Parker@ul.ie (M. Parker), Arlene.McCurtin@ul.ie (A. McCurtin).

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ing student progression, patient safety, service delivery as well as the integrity of professional and accrediting bodies. Recent evidence recommends more extensive exploration of practice-based learning and assessment, in particular the engagement of stakeholder opinion [1,3–5,7]. This will provide valuable insight into factors that challenge and facilitate the PBA process thus guiding further development. Additionally, in light of increasing student numbers required to sustain and grow the physiotherapy workforce globally, it is timely to consider key stakeholders' perceptions of this process in order to support those who support learning in practice-based settings.

Physiotherapy practice, like other health professional disciplines, involves a "hands-on" approach to patient management. This presents a real potential for harm, making the process of training and assessment of students in the workplace a crucial exercise.

Thus, the clinical educator is vital to the PBA process, particularly as these professionals act as gatekeepers to their profession and as protectors of public health in the process. While PBA tools are used globally in physiotherapy education, many are undermined by issues related to reliability and validity [6,8]. Additionally clinical educators can undertake student supervision and assessment with variable levels of clinical and educational knowledge and student mentoring experience [4,9]. Other health professions have addressed similar challenges in PBA by employing multiple modes of assessment, multiple assessors [10–13]. Entrustable Professional Activities (EPAs) (frameworks of collective competencies, which define minimum requirements of students at particular points during their professional programme) [14,15] and programmatic assessment [16,17]. However, while it is acknowledged that a greater bank of evidence exists regarding PBA among professions such as medicine and nursing, it is difficult to directly transfer this knowledge to physiotherapy when readiness for independent clinical practice is a mandatory requirement on graduation. Thus, further research within physiotherapy is needed to determine stakeholders' perceptions of factors such as the routine involvement of one clinical educator in student assessment, and the significant weighting placed on PBA tools in determining readiness for independent practice. These issues were highlighted following a recent systematic review by the authors which identified several similarities across PBA processes used in physiotherapy globally [6]. Knowledge in this area is vital particularly when clinical educators are relied upon to deliver approximately one third of the academic content of physiotherapy programmes through practice-based modules [1,18].

The importance of communication and support structures between the clinical learning environment and university is also critical to practice-based learning [7], particularly as practice-based education occurs remotely from the student's university. Communication deficits between universities and clinical educators have been shown to influence student assessment [19–21] with some evidence suggesting that clinical educators may not be best placed to identify and report underperforming students for reasons including insufficient training and poor support structures between them and their academic colleagues [19,20]. In the Republic of Ireland, practice tutor roles were introduced around 2005 to support clinical educators and students in workplaces facilitating large numbers of students. Practice tutors do not carry a caseload, but instead provide dedicated educational support to students and clinical educators during practice-based modules. These roles are affiliated with universities, and thus may enhance communication between clinical and academic colleagues. However, within physiotherapy, communication issues have not been widely investigated [1,3,21] thus warranting further exploration particularly when the outcome of clinical educators' decision-making in PBA impacts significantly on student progression and patient safety. Further, the employment of dedicated educational roles to support clinical educators and physiotherapy students in the Republic of Ireland provides an ideal landscape to explore stakeholders' perceptions of their value in the process. Thus, while acknowledging evidence-based challenges with PBA tools, and the underrepresentation of stakeholder perspectives in physiotherapy literature regarding PBA, the aim of our study was to explore clinical educators' and practice tutors' perceptions of the PBA process in physiotherapy, in order to identify its challenges and facilitators, with a view towards informing its development.

Methods

Study context

Physiotherapy students in the Republic of Ireland must complete several practice-based modules where clinical performance is assessed by a clinical educator using a nationally agreed PBA tool [22]. Practice-based education is supported on approximately 70% of all sites by a practice tutor [23]. Students attending unsupported sites (no practice tutor) are assessed by a clinical educator only, who has access to support from university staff during the module.

Study design

A qualitative descriptive design was employed as it provides the opportunity to answer questions related to people's perceptions of a particular health environment – in this case the clinical learning environment – and to explore what hinders or facilitates use of a service—in this case the PBA process [24]. Focus group interviews were employed for data collection due to the exploratory nature of the study, their ability to encourage peer discussion, and elicit a number of perspectives on a defined topic in order to reach data saturation [25,26]. Furthermore, in order to gain sufficiently rich data with minimum impact on clinical educators' and practice tutors' work schedules, focus groups were deemed more

Table 1
Question route for participants.

Introduction	Welcome participants and acknowledge appreciation for attendance
Opening questions	• Briefly describe how many physiotherapy students you supervise per year and how many years you have been involved in student supervision and assessment. • What comes to mind when you think about the student assessment process on clinical placements and your role as supervisor and assessor? Any examples positive or negative.
Key questions	• What are your thoughts on observation-based assessment and the assessment form currently used on placement? • What guides you when making your decision on grading a student on placement? • Have you ever experienced a borderline/failing student on placement? How did you approach the grading of this student? How did you decide whether they passed or failed? • In our student interviews, issues were raised around . . .. . . What do you feel about these issues? • What do you think is working well regarding practice education at present? • What areas require more work? How could this be done?
Closing questions	• In summary, this is what we have discussed, these are the key points that have been made. . . • Is that an accurate reflection? • Anything else? • Many thanks for your contribution.

appropriate than one-to-one interviews. A question schedule was designed and agreed by the team (Table 1) which also integrated issues from physiotherapy student stakeholders [5]. The first author (AOC) conducted all interviews.

Participants and recruitment

The Heads of Department of four physiotherapy programmes in the Republic of Ireland were provided with study details; three expressed interest in participating. Research ethics approval was obtained from each university, with consideration given to issues of confidentiality, anonymity, informed consent, access to participants and provision of study information.

Clinical educators and practice tutors affiliated with these universities and having experience of student assessment in the previous two years were eligible to participate. Convenience sampling was employed initially and snowballing technique later to ensure a mix of clinical educators from supported and unsupported sites. Participants were contacted by email *via* gatekeepers. Interested participants contacted the first author whereupon focus group interviews were arranged. Written consent was obtained from all participants. Practice tutor interviews were held separately from clinical educator interviews, as it was felt that discussion regarding perceived roles would flow better in individual groups.

Table 2
Work experience and supervision.

	Years as PT/CE	Students per placement	Students per year
Practice tutor (PT)	5.1 (3.6)	4.6 (1.7)	27.2 (8.1)
Clinical educator (CE)	7.4 (5.5)	1.6 (0.9)	3.1 (3.6)

Data expressed as Mean (SD). Due to their dedicated educational role, Practice Tutors supervise more students than clinical educators, who have a primary service role.

Data analysis

Interviews were audio-recorded, transcribed verbatim and anonymised. Transcripts were checked by (AOC) for accuracy, and returned to participants with a summary of discussion points. Those who responded ($n = 14$) agreed that the summary reflected discussions. Inductive thematic analysis was used to explore the data and an audit trail maintained [27]. Initial coding was completed by (AOC) using specialist software to systematically sort the data (NVivo qualitative data analysis Software; QSR International Pty., Ltd. Version 11, 2015). Data saturation was reached by the third interview for both groups, identified at the point when no new codes or information were found [25,26]. (AMcC) read four of the seven transcripts (chosen randomly) and through discussion, verified and agreed initial coding with (AOC). Over the course of two meetings the codes were collapsed into themes, which were cross-checked against the original transcripts. A process of reflexive discussion occurred with (PC) and consensus was reached on the final themes, thus ensuring rigour of the analytical phase [28].

Results

Seven focus groups were conducted ($n = 46$; 7 hours audio-recorded data). Three included practice tutors ($n = 19$) and four involved clinical educators ($n = 27$) (Table 2). Participants are noted as CE (number–number) and PT (number–number) in this section referring to clinical educator and practice tutor focus groups respectively; for example, PT2-4 refers to the fourth participant from the second PT focus group.

Two themes were identified: tensions in the clinical learning environment and an optimal PBA process.

Tensions in the clinical learning environment

This theme depicts a tug of war struggle between participants' dual roles of preparing students for independent

practice and their primary role of providing health services. Discussions highlighted differences between expectations of adequate student performance on supported and unsupported sites. Two subthemes illustrate these concepts.

Juggling roles

All participants articulated the perceived struggle in performing their roles as service provider and student assessor. Competing agendas included prioritising patient safety, the student learning experience, and their gatekeeping role for their profession.

"My role as an assessor is that I have to protect the service, I have to protect the public, I have to protect the profession. . . that's really challenging." PT1-1.

High expectations to deliver in one area were perceived to detract from the other, thus challenging clinical educators to consistently provide a fair assessment experience for students. For example, large caseloads were perceived to limit clinical educators' opportunities to observe students as much as they would have liked;

"So we'd fall into the category of larger caseloads. . . I suppose you're limited then in what you can see the student do and is that unfair?" CE2-1

Most clinical educators perceived that their primary role was not to the student, but to the patient and that the practice tutor was better placed to deal with students in difficulty:

"We don't often have the time to take them (students) separately . . .but I think the practice tutor bridges that gap. . . ." CE3-5

Ready or not?

The second subtheme reflected further tensions, illustrating how decisions regarding students' readiness for independent practice were reached. Clinical educators, particularly on unsupported sites, identified safety awareness as the key indicator towards deciding the outcome of a borderline student. Clinical educators and practice tutors on supported sites tended to cite broader practice-based evidence when judging borderline students including professionalism, clinical reasoning ability and clinical effectiveness, quoting guidelines from the national PBA tool [22] to ground their decisions, for example:

"I think the basic standard is; assess properly. . .pick out the main problems, and then be able to rationalise some basic treatments. . . that's how I would rationalise 'adequate'. It's not pretty, it's not perfect but it'll do." PT1-3

All participants referred to personal signposts and instinct when probed on how they would quantify achievement of independent practice. References including entrusting a family member to the students' care;

"Would you want them. . .looking after someone belonging to you". CE3-1

And working with students as graduates in a healthcare team;

"So you're kind of conscious of the fact that if you pass them . . . they could be working with you . . ." CE1-7

An optimal PBA process

A clear picture of an optimal PBA process emerged through discussion, illustrated by two subthemes which incorporated perceived benefits of the practice tutor role, and features of the current PBA process perceived to work well.

Maintaining current facilitators

When asked about the current method of PBA, all participants emphasised that observation-based practice should remain central to the process. Most were ambivalent towards additional assessment methods and were critical of the perceived tick-box nature of assessment models undertaken by medical students, for example:

"They come and say to us, will you tick that we've spent time with the physio or SLT· · · They may not have spent time with the SLT . . . you don't want that. . . They need maximum exposure to patients and if that means 100% or 90% observation model, I think that's good. CE3-1

Participants further defended observation-based assessment, augmenting it with other assessment adjuncts, perceiving this increased the trustworthiness of their decisions. These included self-assessment, questioning techniques, feedback tools, and evidence of clinical reasoning in student documentation.

"I would say it's not all just visual observation, you've observed, you've gone through their notes and you've signed them off as well" CE4-6

The concept of pass/fail grading was discussed as an antidote to grade-focused students, which all participants perceived as a deterrent to learning. However, participants agreed that graded assessment was necessary for two reasons; firstly, it motivated student learning:

"I think a pass/fail they just kind of scrape by, . . . we want to kind of get people to be the best that they possibly can be, so grading. . . it's always worked" CE1-4

Secondly, it was perceived that the practice of grading students added credibility to the PBA process and provided evidence of quality assurance to universities and accrediting bodies;

"So for quality assurance as well . . . we can actually stand over our students and the level of education that they're at" CE1-4

Improving standardisation

Differences were perceived by all participants between organisational and support structures on supported and unsupported sites. Clinical educators and practice tutors perceived a more standardised, rigorous approach to PBA on supported sites. Several factors were perceived to contribute to this including greater training opportunities, sharing of responsibilities and greater educational expertise available to students and clinical educators. Furthermore, the throughput of students on supported sites was perceived to foster excellence in student education and assessment, for example PT3-2 said:

"Similar to sites of excellence ... the more students you have, the more exposure you'll have to different levels of performance and that should lead to consistency in terms of grading..." PT3-2

Concern expressed by all participants regarding the grade-focussed nature of students was mitigated by the extra time and resources perceived to be available on supported sites which could be invested in the professional development of the student.

"Whereas with the supported sites it's all about learning and it's about kind of nourishing the student" CE1-2

Discussion

This study, which explored clinical educators' and practice tutors' perceptions of the PBA process employed in physiotherapy education, highlights the diversity and complexity of roles and responsibilities undertaken by clinicians involved in this process. Furthermore, clinicians' desire to provide a transparent and fair assessment experience is often challenged by the nature of the clinical working environment where time restraints, caseload complexity and duty to the public and one's profession could lead to personal conflicts. Nonetheless, a belief pervaded that the process could be improved for the benefit of all stakeholders involved.

Dedicated educational role

Much of the conflict portrayed by clinical educators related to the perceived challenge of providing a good service to both the student and the patient. These anxieties were alleviated on sites where practice tutors were employed for reasons including the sharing of responsibilities related to mentoring and assessment and the perception that training in student facilitation and assessment procedures was more standardised. These factors indicate a common thread related to support structures desired by clinicians who undertake clinical educator roles. The Republic of Ireland adopted practice tutor roles in the mid-2000's, to provide dedicated educational support to students and clinical educators in the workplace following a sharp rise in student intake across health professional programmes. These roles do not involve service provision, concerned only with supporting clinical educators and students during practice-based modules. The need for this support has been highlighted previously as a strategy towards enhancing links between clinical learning environments and universities [7,29]. Our findings, further corroborated by physiotherapy students [5], suggest that the presence of a dedicated educational role in the workplace may improve perceptions of fairness and transparency of the PBA process among stakeholders as well as the reliability of the process and therefore should be more widely considered.

Improving rigour

Clinical educators' and practice tutors' perceptions of factors which determined readiness for independent practice varied between supported and unsupported sites. Clinical educators, particularly those on unsupported sites, regarded safety awareness as the main indicator for deciding the fate of borderline students. Practice tutors and their clinical educator colleagues on supported sites held a broader view of requirements for independent practice which included professionalism, clinical reasoning and effective patient management. While good safety awareness may be a valid indicator of impending performance in early professional education, it is not exclusively linked with effective practice; nor is it sufficient for independent practice [30–33]. The focus on adequate safety awareness articulated by clinical educators on unsupported sites, whether subconsciously or due to the complexity of their role, may reflect prioritisation strategies, where patient safety came first, ahead of all other desirable student learning outcomes. It may also be linked with greater expectations of students on supported sites due to the presence of a practice tutor. Thus, our findings raise questions regarding the availability of sufficient opportunities for clinical educators to identify and report underperforming students. By virtue of the multiple roles reported by clinical educators, particularly on unsupported sites, this may be unavoidable, although not ideal. The practice tutor may help to provide greater standardisation of support structures for students and clinical educators. This is vital, considering the high stakes nature of decision-making involved and the ongoing need for greater physiotherapy student numbers to address global workforce needs into the future.

Further tensions were apparent when participants discussed current grading methods; with clinical educators disapproving of grade-focussed students but conversely, approving graded performance assessments. Notwithstanding, the ethos of practice-based learning is to provide the opportunity to develop critical expertise as a health professional and is not necessarily concerned with grades. Other strategies worthy of consideration in physiotherapy which

motivate student learning over academic achievement include EPA's [14,15], programmatic assessment [16,17] or combinations of graded and ungraded placements [34], all of whichcould help to alleviate the focus on grades.

Conclusion

Our findings add new knowledge in the area of PBA particularly highlighting the complexity of roles undertaken by clinical educators. While this study was confined to Ireland, our recent systematic review [9] determined that physiotherapy PBA tools and procedures internationally have several similarities; thus, our findings may resonate with international physiotherapy education providers. The presence of a dedicated educational role in the workplace, was perceived to have a positive impact on standardisation of the PBA process through support structures provided for clinical educators and students. Thus, wider implementation of these roles may improve the quality of the PBA process among stakeholders and deserves further consideration.

Key messages

1. This study utilises a stakeholder-centred approach to provide new insights into the performance-based assessment process used in physiotherapy practice education.
2. Findings from this study highlight the diversity and complexity of roles and responsibilities undertaken by clinical educators and identifies strategies towards optimisation of this assessment process.
3. The employment of a dedicated educational role in the workplace demands consideration within physiotherapy and health professional education, in light of perceived benefits identified in this study related to standardisation of the performance-based assessment process and educational support for the clinical educator and student.

Ethical approval: Ethical approval for this research was received from the University of Limerick, Ireland (Faculty of Education and Health Sciences Research Ethics Committee) (REF: 2016_02_03_EHS), Trinity College, Dublin, Ireland (Faculty of Health Sciences Research Ethics Committee) (REF: 160302) and the Office of Research Ethics at the University College Dublin, Ireland (REF: EXR-E-16-01-OCONNOR-UL).

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References

[1] Öhman A, Hägg K, Dahlgren L. A stimulating, practice based job facing increased stress—clinical supervisors' perceptions of professional role, physiotherapy education and the status of the profession. Adv Physiother 2005;7(3):114–22.
[2] McMeeken J. Physiotherapy education—what are the costs. Aust J Physiother 2008;54:85–6.
[3] Sevenhuysen S, Haines T. The slave of duty: why clinical educators across the continuum of care provide clinical education in physiotherapy. Hong Kong Physiother J 2011;29:64–70.
[4] Greenfield B, Bridges P, Phillips T, Drill AN, Gaydosik C, Krishnan A, *et al.* Exploring the experiences of novice clinical instructors in physical therapy clinical education: a phenomenological study. Physiotherapy 2014;100:349–55.
[5] O'Connor A, Cantillon P, McGarr O, McCurtin A. Navigating the system; physiotherapy student perceptions of performance-based assessment. Med Teach 2017;19:1–6.
[6] O'Connor A, McGarr O, Cantillon P, McCurtin A, Clifford A. Clinical performance assessment tools in physiotherapy practice education: a systematic review. Physiotherapy 2017;104(1):46–53.
[7] Dean M, Levis A. Does the use of a university lecturer as a visiting tutor support learning and assessment during physiotherapy students' clinical placements? A survey of higher education institution providers. Physiotherapy 2016;102:365–70.
[8] Thomson D, Patterson D, Chapman H, Murray L, Toner M, Hassenkamp A. Exploring the experiences and implementing strategies for physiotherapy students who perceive they have been bullied or harassed on clinical placements: participatory action research. Physiotherapy 2017;103:73–80.
[9] Trede F, Smith M. Workplace educators' interpretations of their assessment practices: a view through a critical practice lens. Assess Eval High Educ 2014;39(2):154–67.
[10] Fahy A, Tuohy D, McNamara M, Butler M, Cassidy I, Bradshaw C. Evaluating clinical competence assessment. Nurs Stand 2011;25(50):42–8.
[11] Hodges B. Assessment in the post-psychometric era: learning to love the subjective and collective. Med Teach 2013;35:564–8.
[12] Moonen-van Loon J, Overeem K, Donkers H, Van der Vleuten C, Driessen E. Composite reliability of a workplace-based assessment toolbox for postgraduate medical education. Adv Health Sci Educ 2013;18(5):1087–102.
[13] Massie J, Ali J. Workplace-based assessment: a review of user perceptions and strategies to address the identified shortcomings. Adv Health Sci Educ 2016;21:455–73.
[14] ten Cate O. Nuts and bolts of entrustable professional activities. J Grad Med Educ 2013;15:7–8.
[15] Pittenger A, Chapman S, Frail C, Moon J, Undeberg M, Orzoff J. Entrustable professional activities for pharmacy practice. Am J Pharm Educ 2016;80(4):1–4.
[16] Wilkinson T, Tweed M. Deconstructing programmatic assessment. Adv Med Educ Pract 2018;9:191–7.
[17] van der Vleuten C, Schuwirth L, Driessen E, Govaerts M, Heeneman S. Twelve tips for programmatic assessment. Med Teach 2015;37:641–6.
[18] WCPT. World Confederation for Physical Therapy guideline for standard evaluation process for accreditation/recognition of physical therapist professional entry level education programmes. London: World Confederation of Physical Therapy; 2011.
[19] Rees C, Knight L, Cleland J. Medical educators' metaphoric talk about their assessment relationships with students: 'you don't want to sort of be the one who sticks the knife in them'. Assess Eval High Educ 2009;34(4):455–67.
[20] Larocque S, Luhanga F. Exploring the issue of failure to fail in a nursing program. Int J Nurs Educ Scholarsh 2013;10(1):1–8.
[21] Trede F, Mischo-Kelling M, Gasser E, Pulcini S. Assessment experiences in the workplace: a comparative study between clinical

educators' and their students' perceptions. Assess Eval High Educ 2015;40(7):1002–16.
[22] Coote S, Alpine L, Cassidy C, Loughnane M, McMahon S, Meldrum D, *et al.* The development and evaluation of a common assessment form for physiotherapy practice education in Ireland. Physiother Ireland 2007;28(2):6–10.
[23] Health Service Executive, Ireland. Health Service Executive report on the review of the practice education system. Dublin: Health Service Executive; 2011.
[24] Colorafi KJ, Evans B. Qualitative descriptive methods in health science research. Herd 2016;9(4):16–25.
[25] Krueger R, Casey M. Focus groups: a practical guide for applied research. 5 ed. Thousand Oaks, CAlifornia: SAGE; 2015.
[26] Fusch P, Ness L. Are we there yet? Data saturation in qualitative research. Qual Rep 2015;20(9):1408–16.
[27] Braun V, Clarke V. Successful qualitative research: a practical guide for beginners. London: SAGE Publications; 2013, 382 p.
[28] O'Brien B, Harris I, Beckman T, Reed D, Cook D. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med 2014;89(9):1245–51.
[29] Francis-Cracknell A, Maver S, Kent F, Edwards E, Iles R. Several strategies for clinical partners and universities are perceived to enhance physiotherapy student engagement in non-metropolitan clinical placements: a mixed-methods study. J Physiother 2017;63:243–9.
[30] WCPT. World confederation for physical therapy. Policy statement: description of physical therapy. London: WCPT; 2017.
[31] WCPT. World confederation for physical therapy. Policy statement: autonomy. London: WCPT; 2017.
[32] WCPT. World confederation for physical therapy. Policy statement. London: Education; 2017.
[33] APC. Accreditation standard for entry level physiotherapy practitioner programs. Australia: Australian Physiotherapy Council; 2017.
[34] Gallagher P. The role of the assessor in the assessment of practice: an alternative view. Med Teach 2010;32:e413–6.