

RESEARCH PAPER

Practitioner perspectives on extended clinical placement programs in optometry

Clin Exp Optom 2015; 99: 248–257

DOI:10.1111/cxo.12337

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Background: Some universities are looking to provide a more diverse range of clinical learning experiences through extended clinical placement programs. This approach will potentially have a significant impact on practitioners. The aim of this study was to conduct a national survey of optometrists to ascertain their perspectives on participating in extended clinical placement programs.

Methods: Members of Optometry Australia were invited to participate in a survey conducted during June and July 2014.

Results: A total of 268 practitioners participated (six per cent of registered Australian optometrists): 159 were predominantly employees or locums and 109 were owners or managers who identified as the key representative of a practice or organisation for the purpose of this survey. Almost two-thirds (65 per cent) of participants, who were employees or locums were supportive of extended clinical placement programs. Among this group, females were more likely to be supportive than males ($p=0.033$). In comparison, just over one-third (34 per cent) of participants who were key decision-makers were supportive, with 30 per cent possibly supportive and 36 per cent not supportive. Among key decision-makers, males were more likely to be supportive ($p=0.009$). The top three perceived advantages of supervising a student were: opportunity to mentor early career development, opportunity to give back to the profession and future recruitment. The top three perceived disadvantages were: burden on time, decrease in number of patients examined and burden on support staff. Suggested incentives for supervising students were credit for continuing professional development and financial remuneration.

Conclusion: There appears to be moderate support for extended clinical placement programs; however, there are incentives that might engage a larger proportion of the profession in the future. These findings can inform the development of effective and sustainable clinical training programs for optometry students. Additionally, the findings might be used as evidence to seek Government support for clinical placement training in optometry.

Submitted: 1 February 2015

Revised: 20 April 2015

Accepted for publication: 28 June 2015

Key words: clinical placement program, optometric education

Training of optometrists in Australia is changing. Until now, students of optometry have predominantly obtained clinical experience in university-based clinics. One way that universities are now looking to provide a more diverse range of clinical learning experiences and enhance student learning is through extended clinical placement programs. These programs involve students providing care to patients in optometric practices under the supervision of optometrists, for a continuous period (typically ranging between four to 26 weeks, at least four days per week), usually toward the end of their training.

While significant integration of extended clinical placement programs into the education of optometric students is a new concept,

such programs, known as longitudinal integrated clerkships (LICs), are now a central feature of many medical schools, particularly in North America and Australia.^{1,2} Longitudinal integrated clerkships were developed as a consequence of the challenges faced by medical doctors training in hospital placements, in particular lack of continuity of patient care and supervision.¹ Although the challenges currently faced by optometric students and schools are quite different, there is broad consensus about the advantages of longitudinal integrated clerkships in medical training, including cohesive learning experiences for students, positive student competency and academic outcomes, as well as positive outcomes for supervising clinicians and

patients.^{1,3} Even so, concerns about longitudinal integrated clerkships have included: inadequate funding and resources, failure to meet defined program goals, variability in the location and nature of some clinics leading to limited experiences, the inexperience of new supervisors, potential for some supervisors to give students an excessive workload, insufficient support for students, who require structure and direction, feelings of isolation among students in remote locations, and the development of problematic relationships between supervisors and students and the subsequent impact on learning.¹

Placing students in optometric practices for extended periods may have a significant impact on the profession. In Victoria alone,

there are approximately 130 students of optometry per year that potentially require placement with practitioners and a further 180 or more in other states of Australia. Assuming each student requires placement with one practitioner, we estimate that placement programs may need to involve approximately seven per cent of the profession each year. Anecdotally, the impression has been that practitioners may be averse to the concept. The aim of this project was to conduct a national scoping survey to ascertain the actual perspectives of Australian optometrists on participating in extended clinical placement programs. Understanding their perspectives is essential in developing placement initiatives that are viable, effective and sustainable.

METHODS

The study adhered to the tenets of the Declaration of Helsinki, and the design, recruitment, consent and procedures were approved by the Deakin University Human Research and Ethics Committee (HEAG-H 67–2014).

A review of the optometric and medical literature did not reveal a survey suitable for the purpose of this study. Hence, we constructed a survey that considered evidence from the medical literature, circulated it to all optometry schools in Australia and New Zealand for feedback and pilot tested it on a sample of eight optometrists representing independent, corporate and academic sectors. The survey comprised two sections. Section A was targeted to individual practitioners and section B was targeted to participants who were owners or managers and identified as the key representative of a practice or organisation for the purpose of this survey (hereafter referred to as ‘key decision-makers’). Section A comprised 12 questions on individual demographics and willingness to support extended clinical placement programs. Section B comprised 29 questions on practice demographics, willingness to support extended clinical placement programs and further details on requirements, as well as perceived advantages and disadvantages (Appendix I).

Participants were recruited via an email to all Optometry Australia members who provide an email address (n = 4,375). The email provided a link to an online version of the survey. The survey was open from 18 June to 4 July, 2014. Two reminders were sent to potential participants via the Optometry Australia e-newsletter.

Quantitative data were analysed using SPSS Statistics Version 20.0 (IBM, Armonk, New

York, USA). Descriptive statistics were computed. Associations between demographic variables and support for extended clinical placement programs were investigated using the chi-square test. All analyses were two-tailed and p-values less than 0.05 were considered statistically significant. Qualitative data were analysed using Nvivo 10 (QSR International Pty Ltd, Melbourne, Australia). Themes were identified by two investigators, one non-optometrist and one optometrist.

RESULTS

Participant characteristics

The sample consisted of 268 optometrists, 146 (54 per cent) males and 122 females, representing six per cent of registered Australian optometrists, as indicated in Figure 1.

The age distribution of participants is provided in Table 1. Participants obtained their entry-level optometry qualifications from a number of universities; 40 per cent from The

University of Melbourne, 28 per cent from the University of New South Wales, 20 per cent from the Queensland University of Technology, five per cent from the University of Auckland and seven per cent from overseas universities. All participants were currently registered to practise as an optometrist within Australia and 162 (60 per cent) were qualified to prescribe therapeutic pharmaceutical agents. The majority of participants were either current employees or locum optometrists in clinical practices or owners, partners, managers or administrators who identified as key decision-makers (Table 1).

Of those participants who were employees or locum optometrists in clinical practice and those who were partner/manager or administrator optometrists in clinical practice but not the key decision-maker (n = 133), 74 per cent practised optometry more than 32 hours per week, 18 per cent practised 16 to 32 hours per week and the remainder (eight per cent) practised fewer than 16 hours per week. The settings in which these participants practised are provided in Figure 2.

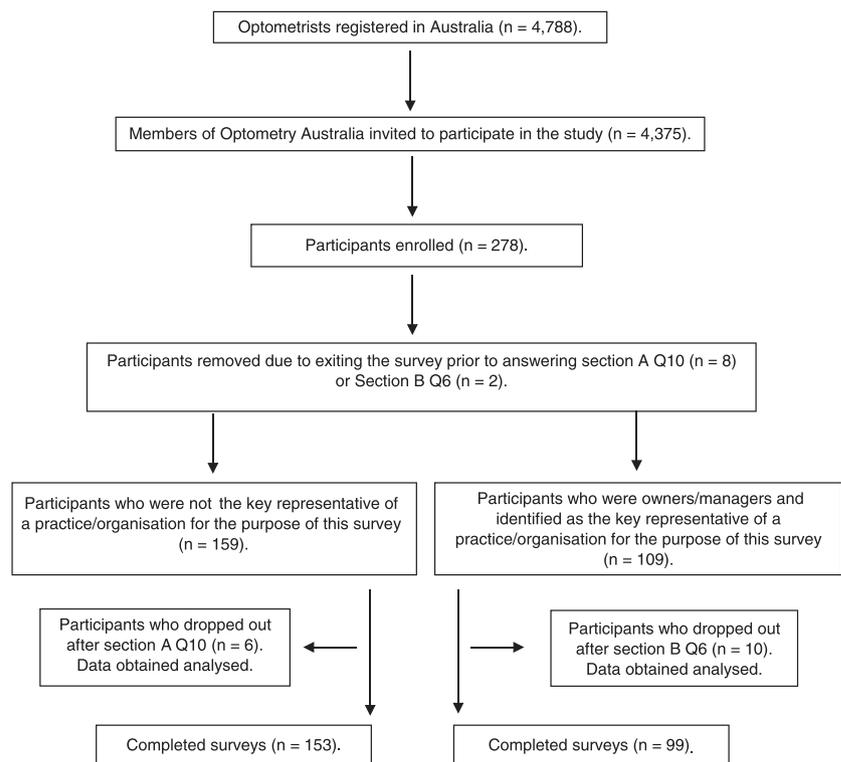


Figure 1. Participant recruitment and flow. Note: section A Q10 and section B Q6 pertain to the primary study aim, willingness to support extended clinical placements, where section A was completed by participants who were not key representatives and section B was completed by participants who were key representatives.

Characteristic	Number of responses		Overall percentage
	Male (%)	Female (%)	
Age			
20 – 29 years	20 (14)	36 (30)	21
30 – 39 years	30 (21)	34 (28)	24
40 – 49 years	35 (24)	30 (25)	24
50 – 59 years	50 (34)	19 (15)	26
60 – 69 years	9 (6)	3 (2)	4
70 – 79 years	2 (1)	0 (0)	1
Total	146 (100)	122 (100)	100
Current primary employment status	Male (%)	Female (%)	
Employee or locum optometrist in clinical practice	41 (28)	73 (60)	42
Owner/partner/manager or administrator who is the key representative of the optometric practice/organisation for the purpose of this survey (key decision-maker)	78 (53)	31 (26)	41
Partner/manager or administrator optometrist in clinical practice	14 (10)	5 (4)	7
Academic – optometry related	4 (3)	5 (4)	3
Manager or administrator – public eye care institution	3 (2)	2 (2)	2
Research role – optometry related	2 (1)	3 (2)	2
Not currently working in an optometric role	2 (1)	3 (2)	2
Manager or administrator – optometry teaching institution	1 (1)	0 (0)	0.5
Retired	1 (1)	0 (0)	0.5
Total	146 (100)	122 (100)	100

Table 1. Participant characteristics

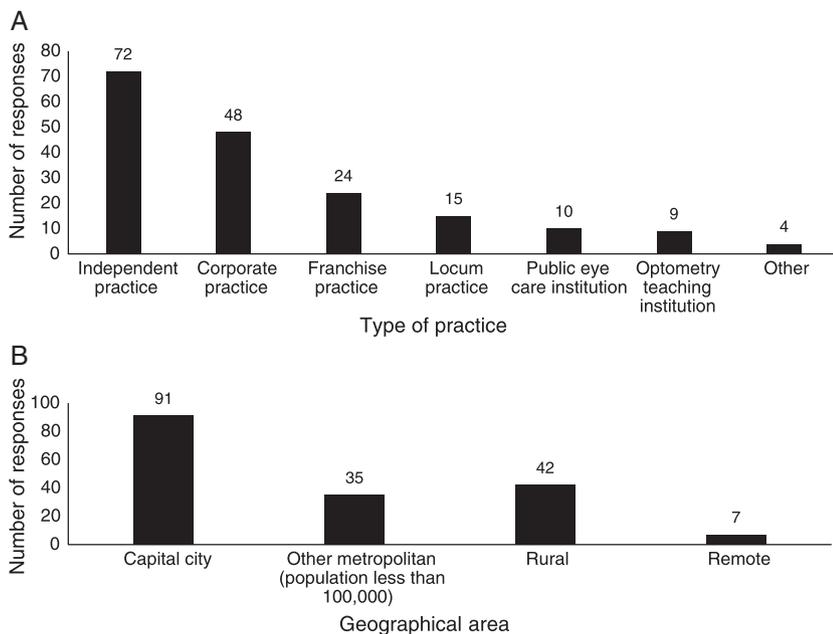


Figure 2. Practice types (A) and geographical areas (B) of participants who were employee/locum partner/manager/administrator optometrists in clinical practice, but not the key decision-maker of a practice/organisation for the purpose of this survey (n = 133). Note that participants could select more than one response.

Of the 109 key decision-makers, the majority (74 per cent) operated one full-time equivalent practice, 15 per cent operated two full-time equivalent practices, nine per cent operated between three and 15 full-time equivalent practices and two per cent operated more than 20 full-time equivalent practices. The majority operated independent practices (Figure 3A). The distribution of geographical locations is shown in Figure 3B. Forty per cent operated with one full-time equivalent optometrist, 32 per cent with two, 15 per cent with three, 14 per cent with between four and 20 and only one per cent with more than 20 full-time equivalent optometrists. Of these practices or organisations, 59 per cent had previously supervised students on placement from various universities.

Support for extended clinical placement programs

Of the 159 participants who were not the key decision-makers for the purpose of this survey, 104 (65 per cent) responded that they were supportive of the idea of extended clinical placement programs for students of optometry (Table 2). When asked if they would be willing to supervise a student on an extended clinical placement program, if supported by their practice or organisation, 50 per cent responded ‘yes’, 26 per cent responded ‘maybe’, while 15 per cent responded ‘no’ (note: eight per cent responded ‘not applicable’, as they did not currently practise optometry).

As shown in Table 2, of the 109 participants who were the key decision-makers, 34 per cent were supportive of the idea of extended clinical placement programs. The participants who were supportive, responding ‘yes’ (n = 37) or ‘maybe’ (n = 33), were asked what minimum and what maximum full-time period their practice or organisation would be prepared to supervise a student. On average, the minimum was 3.1 ± 2.8 weeks (range: 1 to 20 weeks) and the maximum was 9.7 ± 9.0 weeks (range: 1 to 52 weeks). The majority (86 per cent) indicated that they would be willing to supervise only one student, some (13 per cent) indicated two students and one per cent indicated six to 10 students at any given time.

When asked whether they would be willing to provide experience and supervision in full-scope optometry, 94 per cent of supportive participants said that they would be willing to provide supervision on all aspects of patient care and the business. Figure 4

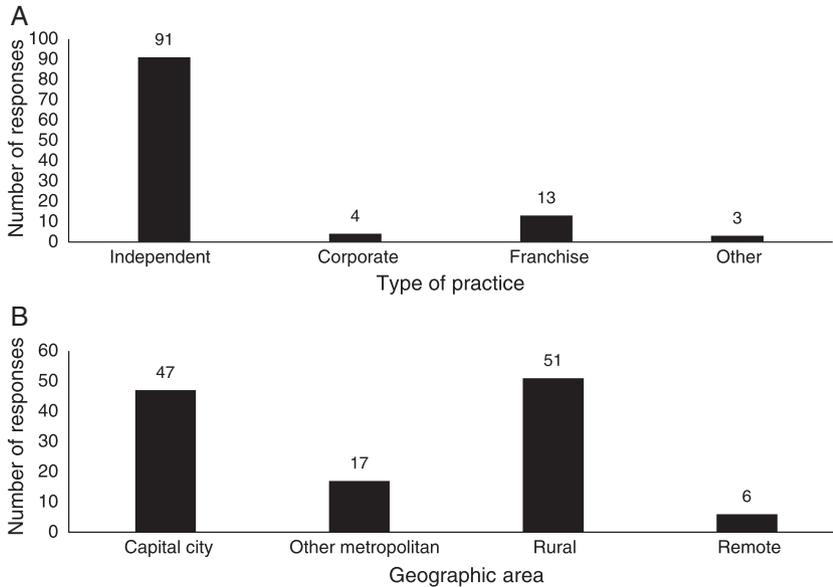


Figure 3. Practice types (A) and geographical areas (B) of participants who identified as the key decision-maker owner/manager of a practice/organisation (n = 109). Note that participants could select more than one response.

Support for extended clinical placement programs	Number of responses	%
Participants who were not the key decision-maker of a practice/organisation		
Yes	104	65
Maybe	33	21
No	22	14
Total	159	100
Participants who were the key decision-maker of a practice/organisation		
Yes	37	34
Maybe	33	30
No	39	36
Total	109	100

Table 2. Support for extended clinical placement programs

provides an overview of the tasks that supportive participants believe, in addition to patient consultations, would be particularly useful to the practice or organisation for the student to do.

The reasons why some key decision-makers (n = 39) were not supportive of the idea of supervising a student on an extended clinical placement program now or sometime in the next two years are listed in Table 3. The top responses included ‘concerned about burden on time’, ‘potential for reduced number of

patients examined’, ‘too busy’, ‘concerned about patients not wanting to be examined by a student’, ‘potential for decrease in revenue’ and ‘lack of space’. ‘Other’ reasons were related to time issues, the practice having too few patient consultations, multiple challenges related to providing services predominantly in aged-care facilities and the perception that current optometric students are too young and not properly selected.

Key decision-makers who were not supportive of taking a student on an extended clinical

placement (n = 39) were asked if they would be interested in taking a student on placement for observation only. Thirty-five per cent responded ‘yes’, 27 per cent ‘maybe’ and 38 per cent ‘no’ to taking a student on observation only clinical placement. Asked if they would be interested in supporting an extended clinical placement program some time in the future, eight per cent (of 35; two participants did not answer this question or the questions that followed) responded ‘yes’, 35 per cent responded ‘maybe’ and the majority, 57 per cent responded ‘no’.

Operation of extended clinical placement programs

The results for this and the following sections pertain to the questions asked of key decision-makers.

For participants who identified as the key decision-maker and were supportive of the idea of the extended clinical placements (n = 62), perceived advantages of supervising a student on extended clinical placement are listed in Table 4 and the perceived disadvantages in Table 5. The top three advantages included ‘mentor early career development’, ‘opportunity to give back to the profession’ and ‘future recruitment’. The top three disadvantages included ‘burden on time’, ‘decrease in number of patients examined’ and ‘burden on support staff’.

Participants were asked to provide their own reasons for wanting to supervise a student on extended clinical placement. Responses are grouped by theme in Table 6. When participants were asked what overall impact they believed that supervising a student on extended clinical placement would have on the number of patients examined and billed in their practice/organisation, 61 per cent of 61 who responded believed that the impact would result in fewer patients examined and billed. Only two per cent of participants believed that the impact would result in more patients, while 31 per cent believed that it would result in the same number of patients and six per cent of participants were not sure.

Barriers and incentives

Participants were asked their opinion about possible barriers their practice or organisation might face, if they participated in an extended clinical placement program. The top three responses included ‘lack of time’ (39 responses), ‘lack of financial remuneration’ (25 responses) and ‘lack of space’ (21 responses)

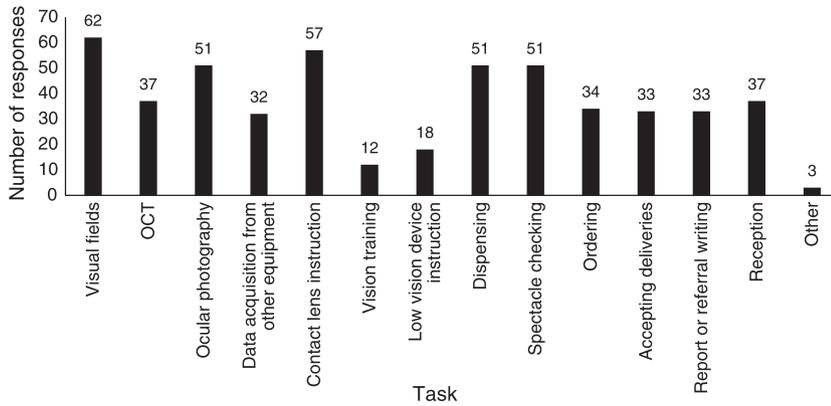


Figure 4. Tasks considered useful for students on extended clinical placement programs to complete. Note that participants could select more than one response.

Reasons	Number of responses	% of responses	% of participants responding
Concerned about burden on time	19	12	49
Potential for reduced number of patients examined	17	11	44
Too busy	16	10	41
Concerned that patients do not want to be examined by students	16	10	41
Lack of space	15	9	38
Potential for decrease in revenue	15	9	38
Concerned about patient dissatisfaction	14	8	36
Potential burden on support staff	12	8	31
Concerned about students making errors with patients	12	8	31
Other	10	6	26
Lack of equipment	8	5	21
Not confident about teaching	4	3	10
Not interested in teaching	1	1	0.03
Waiting to see what happens with others first	0	0	0
Not applicable	0	0	0
Total	159	100	-

†Note that participants could select more than one response.

Table 3. Reasons for not wanting to supervise a student on extended clinical placement (n = 39 of 109 key decision-makers)[†]

as indicated in Table 7. A number of participants responded ‘other’ and provided specific comments on barriers (Table 8).

Participants were also asked about what might encourage their practice or organisation to participate in an extended clinical placement program. The top two responses included ‘continuing professional development credit’ (41 responses) and ‘financial

remuneration’ (38 responses), as indicated in Table 9. Participants who responded ‘other’ provided a range of different responses, such as:

- ‘Just being asked is a good start.’*
- ‘Assistance in allocating placements to ensure extended viability for a longer placement.’*
- ‘Having the university supply us with cutting*

edge research information i.e. summaries or important articles. Complementary clinical education and education workshops put on by the university. Access to online learning modules (perhaps that the student have access to).’

‘Some form of recognition.’

When asked what specific support they would need or expect from a university to participate in an extended clinical placement program, 27 participants (45 per cent) reported that they did not need or expect any support. The 33 participants (55 per cent), who reported that they did need or expect support from a university were asked to comment and responses are summarised in Table 10.

Student experience and approach

Participants were asked how many comprehensive patient examinations they expected students to have managed under supervision prior to commencing an extended clinical placement program. Thirty per cent of 60, who responded expected students to have managed between 10 and 20 comprehensive patient examinations, 16 per cent expected between 25 and 40, 38 per cent expected between 50 and 100 and 12 per cent expected more than 100 patient examinations.

Participants were asked whether they would prefer the student or the university to approach them initially about the extended clinical placement program. The majority of participants (62 per cent) preferred the university to approach them in the first instance, eight per cent preferred the student approach and 30 per cent had no preference. When asked whether they would be more likely to take on a student from their own geographical location than a student from elsewhere, the results were mixed, with 48 per cent of participants responding that they would be more likely and 52 per cent that they did not have a preference. When asked if they would be more likely to supervise a student who, in addition to English, spoke a second language that reflected the language spoken by a significant proportion of the patients attending their practice, the majority (88 per cent) did not have a preference, seven per cent were more likely and five per cent were less likely. The majority of participants (70 per cent) were unable to offer or facilitate accommodation for students on extended clinical placement programs.

Advantages	Number of responses	% of responses	% of participants responding
Mentor early career development	52	16	84
Opportunity to give back to the profession	49	15	79
Future recruitment	46	14	74
Gain knowledge on the latest development	29	9	47
Develop or enhance teaching skills	27	8	44
Renewed motivation	25	8	40
Extra help around the practice	24	7	39
Extra help with patients	22	7	35
Affiliation with a university	22	7	35
Variety	15	4	24
Access to university resources (e.g. library, e-journals)	13	4	21
Increase in number of patients examined	3	1	0.05
Other	2	0.05	0.03
Increase revenue	1	0.05	0.02
None	0	0	0
Total	330	100	-

†Note that participants could select more than one response.

Table 4. Perceived advantages of supervising students on extended clinical placement programs (n = 62 of 109 key decision-makers)†

Disadvantages	Number of responses	% of responses	% of participants responding
Burden on time	55	29	89
Decrease in number of patients examined	31	16	50
Burden on support staff	28	15	45
Decrease in revenue	21	11	34
Difficulty finding patients willing to be examined by a student	17	9	27
Patient care errors	14	7	23
Patient dissatisfaction	14	7	23
Other	9	5	0.1
None	3	1	0.05
Total	192	100	-

†Note that participants could select more than one response.

Table 5. Perceived disadvantages of supervising students on extended clinical placement programs (n = 62)†

Practice accreditation and training

Participants were asked whether their practice or organisation would be willing to undergo a complimentary accreditation process to confirm their suitability for participation in extended clinical placement programs. The majority of participants (88 per cent of 60)

responded that their practice would be willing to undergo such a process.

With regard to clinical supervisor training, 65 per cent of participants responded that they would be willing for the employed optometrists in their practice or organisation to undergo a complimentary program, eight per cent would

not be willing and 27 per cent responded that the majority of their employed optometrists already had training and/or experience. Of the 39 participants willing to undergo a clinical supervisor training program, 24 per cent had a preference for in person training, 33 per cent for online delivery, 28 per cent for combined in person and online delivery and 15 per cent had no preference. Preferences for the duration of training are shown in Figure 5.

Factors associated with support for extended clinical placement programs

For the purpose of analysing factors associated with support for extended clinical placement programs, participants who indicated support by answering, 'yes' or 'maybe' were combined and compared with those who answered 'no'. A significantly greater proportion of participants who were not key decision-makers (predominantly employees and locums) were supportive compared with participants who were key decision-makers (owners and managers) (chi-square = 17.71, p < 0.001). Furthermore, there was a significant association between gender and support for clinical placement programs. Among employees and locums, females were more likely to be supportive than males (chi-square = 4.54, p = 0.033); however, the reverse was true among key decision-makers, with males more likely to be supportive than females (chi-square = 6.85, p = 0.009). Key decision-makers were also more likely to be supportive, if they had previously supervised students (chi-square = 6.72, p = 0.035). There were no significant associations between support for clinical placement and age, where participants obtained their qualifications or whether they were qualified to prescribe therapeutic pharmaceutical agents.

DISCUSSION

To our knowledge, this is the first time the optometric profession has been surveyed on their views of student clinical placements anywhere in the world. Consultation with and understanding the perspectives of practitioners is essential in developing placement initiatives that are viable, effective and sustainable for both practitioners and universities. Furthermore, determining what is needed for placements to be successful from the practitioner's perspective will assist future planning and provide part of the evidence required for our profession to seek funding for clinical training from government, as is the

Theme	Number of responses	Example of responses
Give back to the profession	9	Giving back to profession, share knowledge and time... I had a pre-reg Year in UK and it was the most exciting, demanding and inspirational time of my life. I wish to give that back to someone.
Expose students to a broad range of experiences	8	I would like to expose a student to full scope independent optometry, especially examination of children and advanced contact lens management including ortho-keratology. Assist universities to provide clinical experience in contact lens related optometry, because they do not seem to be provided with that clinical experience in the university clinics. Sharing knowledge in paediatrics so early career Optometrists can be more comfortable and accomplished in delivery of care to young patients. To expose students to patients with eye diseases not normally seen in the clinical schools.
Preparing students for the real world	6	Real world experience is very valuable and I was supported this way by other optometrists... Placements outside of university setting offer 'real life' learning and this should bridge the gap from institutional setting to real settings for students jumping to their new jobs.
Future recruitment	5	... finding future staff / succession planning... Potential recruitment... Someone has to learn conical fittings, sclerals, ortho-k as I will want to retire in 15 years and there will still be patients to be seen!
I enjoy teaching	4	I like teaching - it adds more interest to my day. I have enjoyed informal teaching of students in the past.
Learning from students	4	I enjoy the challenge and learning new things from students... ...being inspired by a young practitioner... ...I have also found working with younger optometrists enhances my skills.
To stay ahead of latest knowledge and developments	3	Good to keep 'in the loop' and hear how optometry training is changing... Access to new techniques and ideas. We want to stay at the forefront of the profession and we see having a student as a way to drive that...
My own personal and professional development	3	Personal growth - both in the clinical area and in the teaching area... ...develop supervision / teaching skills...
To mentor students	3	I would enjoy sharing my experience with someone else. I feel that this would be beneficial for both student and mentor. To pass on my practical skills which would complement their academic training. Act as mentor/role model for young optometrists.
Allow students to have rural experiences	2	My practices in rural locations are interesting places to work, I would like students to experience interesting optometry, and then consider coming to the country. ...extending the students practical experience with exposure to general rural practice.
Extra help around the practice	1	An extra set of well-trained hands to act as a clinical assistant.

†Note that 37 participants commented, with some listing more than one reason and 24 participants did not have any additional comments.

Table 6. Reasons for wanting to supervise students on extended placement (n = 61) †

case in medicine and nursing. Almost two-thirds of participants in this study who were employees and locums (not key decision-makers of a practice or organisation) were supportive of extended clinical placement programs for students of optometry in Australia. In comparison, just over one-third of participants who were owners and managers (key decision-makers of a practice or organisation) were supportive, with 30 per cent possibly supportive and 36 per cent not supportive. Of the key decision-makers who were

supportive, the preferred duration of the placement varied considerably, from a minimum of approximately three weeks to a maximum of 10 weeks. The main barriers to supervising students on extended clinical placement programs for key decision-makers were, first, lack of time, followed by lack of financial remuneration and lack of space, while the main potential incentives were credit for continuing professional development and financial remuneration. Although most key decision-makers responded that

their practice would be willing to undergo a complimentary accreditation process, only two-thirds indicated that they would be willing for their employee optometrists to undergo a complimentary training program for supervisors.

Although optometrists in this survey had a preference for relatively short extended clinical placement programs (the median duration of such programs in medicine is 40 weeks²), the experience of medicine is that longer placements are preferred to allow

Barriers	Number of responses	% of responses	% of participants responding
Lack of time	39	33	64
Lack of financial remuneration	25	21	41
Lack of space	21	18	34
Other	13	11	21
Lack of equipment	8	7	13
Nothing	7	6	11
Lack of supervisor training	5	4	0.08
Total	118	100	-

†Note that participants could select more than one response.

Table 7. Perceived barriers to extended clinical placement programs (n = 61 of the initial sample of 109 key decision-makers)†

Theme	Number of responses	Example of responses
Student costs	2	We are in a regional city, so the costs of accommodation, travel and flights need to be covered by the student. Have supervised 2 last year (they organised own costs). Cost to students of transport and accommodation in regional setting.
Student travel	1	Distance of travel, we are not in the same location as any of the schools of optometry.
Location	1	Remote location.
Lack of space	1	Would have to remodel my auxiliary area (VFT at the moment) to include partitioned area for student to use for pre-testing/patient instruction etc., so that they can work in their own space. Our second practice location has greater room for this.
Lack of equipment	1	We have 3 optometrists and 3 rooms. Ideally need a 4th room fitted out for the student to work in whilst the rest of us are still consulting. We have the space, but would need the equipment.
Student fit	1	Getting the right student - some students are great and actively participate, while others are 'leeches' just going through the motions to tick the box to complete. I won't accept some.
Student experience	1	Student may not acquire enough experience.
Patient acceptance	1	Patient acceptance of the process.
Oversupply of optometrists	1	Not sure I want to help add to the current oversupply of optometrists
Placements not a fall back for universities	1	Clinical training is a privilege both to the supervisor and student. It should not be used as a fall back by the university not being able to provide a proper course structure within its own environment.
Loss of income from dispensing	1	...The student is focussed on a clinical outcome and sometimes the subtleties of the dispensing part of the consultation may be missed.

Table 8. 'Other' comments on barriers to extended clinical placement programs

the rapport between practitioner and student to develop, in tandem with the progressive clinical participation and maturation of clinical skills of the student.^{2,4} While there is no consensus on the optimum duration of placement and research on this is required,⁵ placements of longer than eight weeks (the traditional duration of medical specialist rotations) have been recommended in medicine.² At the least, there needs to be sufficient time for continuity of care, supervision, assessment, learning and context to be established.⁵ Better still, is for the placement to be of sufficient duration such that the student reaches and goes beyond what Worley and Kitto⁶ identify as the 'turning point' – the point at which the student becomes of daily benefit to the practice.

Barriers and incentives identified for optometrists in this study are consistent with those identified for general medical practitioners (GPs) in previous studies. Barriers in general practice include lack of infrastructure and space, inadequate funding for teaching, loss of supervisor income, increased liability and time constraints.⁷⁻⁹ Despite perceived barriers among GPs, many in Australia are involved in supervising students. Interviews with GPs have revealed that the reasons for their involvement include: appropriate incentive payments and infrastructure support, love of teaching, commitment to educating future clinicians, engagement with the educational institution and recruitment.^{3,4,10} Indeed, medical clinical placement programs are supported by substantial Government funding, such as the Practice Incentives Programme Teaching Payment for general practitioners.¹¹ Regardless, the success of a placement program will also depend on adequate preparation and support of students and clinicians by the educational institution.¹ Without each of these in place for optometry – adequate financial remuneration, preparation and support – there is a risk that practitioners may take students initially but cease to be involved if the demand on their time and resources is too high. This could lead to insufficient placements and the inability of a school of optometry to fulfil its obligations to the student.

Although extended placement programs are different from the long-established pre-registration placement program in the United Kingdom (UK), which is longer and not administered by a university program, it would be useful to compare perceived advantages and disadvantages of each; however, we were unable to find any research literature on

Incentives	Number of responses	% of responses	% of participants responding
Continuing professional development credit	41	25	67
Financial remuneration	38	23	62
Supervisor training	19	12	31
Access to university library, e-journals and learning materials	19	12	31
University affiliation	18	11	30
Additional equipment	16	10	26
Other	7	4	11
Nothing	4	2	0.07
Total	162	100	-

†Note that participants could select more than one response.

Table 9. Perceived incentives for extended clinical placement programs (n = 61)†

Theme	Number of responses	Example of response
Guidelines and/or checklist of student competencies	7	Competency check list/progress expectations etc. A guideline on what clinical tests you expect the student to undertake. Clear guidelines on communication back to uni of clinical competence of the student.
Contact with a university	6	Contact with a university clinical supervisor. Regular contact from university. A contact person at the university available for discussion before/during/after student placement.
Instruction on university expectations	5	Fairly minimal - clear outline of any expectations the university would have for the conduct of the placement. Comprehensive instructions on exactly what type of exposure the university is looking for e.g. more clinical? More dispensing?
Prior knowledge of student background	4	Background of student strengths/weaknesses. Prior knowledge of any difficulty in communicating in English. The level the student is at with a breakdown on their weaknesses and strengths (e.g. binocular vision, dispensing etc.) so that we can tailor the program to the student.
Remuneration	4	Financial remuneration - these students are paying the university a significant fee for their training; however, their supervisors in practice (us) receive no reimbursement at all. This is not offset by the limited 'help' the students would provide to the practice.
Feedback	3	Feedback from university
Supervisor training	3	Clinical supervisor training... Teaching skills.
Additional equipment	2	Assistance in equipping an extra consulting room, plus some university assistance in accessing libraries etc. \$\$ is nice, but may not be a deal breaker if we had the equipment.
Library and resource access	2	Access to university library and resources.
Student pre-training	2	My primary concern would be to ensure that the students are professional in their behaviour and have decent interpersonal skills. This should be part of training to attending an external practice.
Unsure	2	Not sure at this stage. I would need to investigate further the practicalities of having a student on placement.
Ability to end placement	1	Ability to terminate if not working out.
Marketing resources for patients	1	Marketing support - materials for patients that explain the role of the student in the practice, materials that explain to support staff the role of the student.
Ability to interview student for placement	1	Interview a number of prospective students prior to program to find most suitable.
Insurance	1	Insurance.

†Note that participants could make more than one comment.

Table 10. Support needed or expected from a university (n = 60)†

the advantages and disadvantages of the UK program.

Limitations of this study include a low response rate (six per cent) and under-representation of some practise modalities. It is possible that practitioners with extreme, highly positive and highly negative attitudes to extended clinical placements responded. Furthermore, while the sample of participants is representative of optometrists in Australia with respect to age, gender and primary activity,^{12,13} the majority of participants in this study were from independent practices and regional and remote practitioners were somewhat over-represented.¹⁴ Thus, care should be taken in interpreting the results. An additional limitation is that participants were not given any details about the commitment

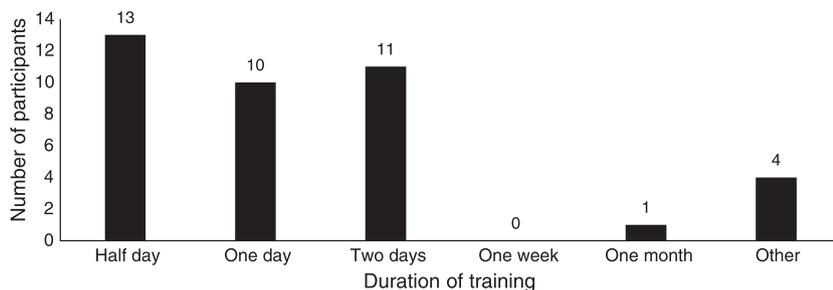


Figure 5. Preferred duration of clinical supervisor training (n = 39)

involved in the supervision of a clinical placement, and that their responses may have been different if the commitment is more or less onerous than they had assumed when responding. It is important to follow-up in the future with a larger sample and to evaluate changes in perceptions as clinical training in optometry evolves and more details on various programs become available.

Based on the results of this study, we suggest that there is moderate support for extended clinical placement programs among optometrists at this time. Optometrists are primarily concerned about lack of time, lack of financial remuneration and lack of space to support students. Furthermore, they would benefit from guidelines on the goals expected to be achieved by students on placement, regular contact with schools and instructions on university expectations for the conduct of the placement. Additionally, university schools of optometry might carefully consider the duration of extended clinical placement programs. Incentives that might engage a larger proportion of the profession in future are credit for continuing professional development and financial remuneration. These findings will inform the development of effective and sustainable clinical training programs for students of optometry.

ACKNOWLEDGEMENTS

This study was funded by the Victorian Optometrists Training and Education Trust.

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