Exploring barriers, advantages and potentials in realising clinical education in private physiotherapy practice settings in Germany

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Abstract
Background: Traditionally, the clinical education of physiotherapy students in Germany takes place in inpatient settings. Against the background that the majority of graduated physiotherapists work in private settings like private practices, this education structure is no longer viable. Therefore, there is a need to develop models of cooperation between private practice and schools of physiotherapy. Aim: The aim of this study is to describe advantages, barriers and options of collaboration between physiotherapy educational institutions and private practices. Methods: A qualitative interview study was conducted, in which two practice owners of a physiotherapy practice and two programme directors were interviewed using a problem-centred interview approach. All participants were contacted via email or telephone. Textual data was analysed using thematic analysis, to inductively discover and describe relevant themes. Results: The economic conditions of private practices in Germany, legal requirements and training regulations are identified as the main barriers preventing forms of collaboration. One of the advantages of offering students practical placements is their probable future employment. Successful collaboration may depend on remunerating clinical instruction time, relaxing legal requirements or increasing the participation of schools in practical training. Conclusion: Private practice needs financial and content-related support to engage in clinical education. Health insurance companies or the government could act as financial sponsors.

Keywords: clinical education, communication, curriculum, practical guidance
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Introduction

Physiotherapy education programmes aim to qualify “physical therapists for practice as independent autonomous professionals” (World Confederation of Physical Therapy, 2011). Therefore, clinical education is an integral part of any physiotherapy education programme worldwide. The World Confederation of Physical Therapy guideline for the clinical education component of physical therapist professional entry-level education claims that physiotherapists need to be equipped to work in a variety of different practice settings, like “institutional, industrial, occupational, primary health care, and community settings” (World Confederation of Physical Therapy, 2011). Despite this recommendation, clinical education is delivered mainly in clinical settings, like acute care hospitals or inpatient rehabilitation clinics (Baldry Currens & Bithell, 2000; Davies et al., 2011; Dean et al., 2009; Doubt et al., 2004; Holland, 1997; Kent et al., 2015; McCallum et al., 2013; McMahon et al., 2014; Wells, 2016). Although a large number of graduates work in primary health care settings, like private physiotherapy practices, this practice setting is underrepresented in clinical education due to different reasons.

Private practice settings in this article are defined as settings in which physiotherapists provide physiotherapy services for the public, irrespective of the kind of funding or the ways of referral to that service. Despite this, the majority of treatments in private practices in Germany is funded by public health insurances.

Nevertheless, looking at the demands and characteristics of different practice settings, physiotherapists working in primary health care settings will face other organisational structures (e.g. time management) and patients (e.g. large number of chronic pain patients) (Atkinson & McElroy, 2016; Solomon & Miller, 2015). Currently, novices very often feel ill-prepared to work in primary health care settings, like private practices (Ernstzen et al., 2014; Jones, McIntyre & Naylos, 2010; Wells, 2016). As Solomon and Miller (2005) and Kent et al. (2015) describe, they often feel overwhelmed by the complex demands in private practice settings, resulting from time-management, administration tasks, lacking communication strategies and clinical-reasoning skills. Therefore, integrating primary health care settings, as part of clinical physiotherapy training especially private physiotherapy practices can offer a positive contribution to clinical education and can have a positive impact on private practice, such as the recruitment of new employees (Baldry Currens & Bithell, 2000; Doubt et al., 2004; Kent et al., 2015; Recker-Hughes et al., 2014; Sloggett et al., 2003). Furthermore, participating in the training of physiotherapists could have a positive impact on patients by transferring the image of a learning organisation which is linked to high-quality treatments (Recker-Hughes et al., 2014; Sloggett et al., 2003; Thompson & Proctor, 1990). Therefore, integrating primary health care settings, as part of clinical

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physiotherapy training especially private physiotherapy practices can offer a positive contribution to clinical education and can have a positive impact on private practice, such as the recruitment of new employees (Baldry Currens & Bithell, 2000; Doubt et al., 2004; Kent et al., 2015; Recker-Hughes et al., 2014; Sloggett et al., 2003). Furthermore, participating in the training of physiotherapists could have a positive impact on patients by transferring the image of a learning organisation which is linked to high quality treatments (Recker-Hughes et al., 2014; Sloggett et al., 2003; Thompson & Proctor, 1990).

However, many barriers to realising clinical education in private physiotherapy practice settings are described in the literature. Usually, practice owners receive no additional payment for the invested time. Therefore, taking on clinical instruction of physiotherapy students is perceived as unattractive (Baldry Currens & Bithell, 2000; Davies et al., 2011; Doubt et al., 2004; Jette et al., 2014; Kent et al., 2015; McMahon et al., 2014). Additionally, the unpredictability of patients' characteristics and diagnoses (Sloggett et al, 2003; McMahon et al., 2014), liability concerns (Baldry Currens & Bithell, 2000; Doubt et al., 2004; Sloggett et al., 2003) and the fear of decreased patient satisfaction (Doubt et al., 2004; Lo et al., 2017) are listed as barriers. Despite this, practice owners criticise that students are not sufficiently prepared for placements in the private sector, which is consistent with novices' self-perception of their readiness to work in the private sector (Atkinson & McElroy, 2016; Dean et al., 2009; Kent et al., 2015). Depending on the legal situation in different countries, students are not allowed to treat patients in cases where public health insurance was paying (Davies et al., 2011; Doubt et al., 2004; Kent et al., 2015; Maxwell, 1995).

Due to large variations of legal requirements among different countries, it is not possible to offer a general solution for integrating different practice settings in clinical physiotherapy education. Instead it requires an individual analysis of relevant national physiotherapeutic educational standards and legal regulations of the respective national health care system. Therefore, this study focuses on exploring certain aspects of clinical physiotherapy education in Germany.

Entry-level physiotherapy education in Germany is conducted by either vocational schools (offering state examination and registration) or Universities of Applied Sciences as well as Universities (offering a bachelor's degree). Irrespective of the institutional assignment, clinical education in physiotherapy programmes consists of 1 600 hours of learning in the form of practical training. There is no general legal description of the qualifications required from clinical practice educators or the formal cooperation between school/faculty and clinical education site. As described above, in Germany most if not all clinical education takes place in acute care hospitals and sometimes rehabilitation centres (VDB, 2015). In contrast to this, two-thirds of the physiotherapists in Germany work in the primary health care sector (Destatis, 2017). Studies focusing on the demands that German physiotherapists meet in primary care settings confirm the discrepancies between current contents of physiotherapy education and actual working reality (Lehmann et al. 2015; Grafe & Probst, 2012; Grafe & Behrens, 2019).

Therefore, this study focuses on analysing the specific barriers, advantages and potentials in realising clinical physiotherapy education in private practice settings in Germany.

Methodology and Methods

Design

The overall aim of this study was to explore barriers, advantages and potentials for realising clinical education in private practice settings specific to the German education and health care system. Given this focus, we developed a qualitative study design, which allows us to integrate different stakeholder perspectives.

Participants

To integrate different stakeholder perspectives, we conducted a criterion-based sampling according to Patton (1990). The sampling process aimed to include private physiotherapy practice owners as well as study programme directors that are also responsible for the coordination of clinical education. By including these two perspectives, we followed the assumptions that it is necessary to take into account both perspectives to understand why clinical education has not yet been realised in private practice settings in Germany so far. The sampling was conducted in the federal state of North-Rhine Westfalia, Germany, where approximately 55 vocational and higher education programmes are being offered.

All participants had to be qualified state registered PTs with a minimum of five years of work experience in their current role as director of a study programme or a practice owner. Furthermore, private practice owners should employ at least two physiotherapists, due to the assumption that practices need to have some personal resources to engage in clinical education.

Participants were identified by conducting an internet search and by referring to suitable individuals as known professionally by the authors. All participants were contacted via email or telephone. Upon the initial invitation, the subject of the interview and the inclusion criteria were outlined. Recruitment continued over a 3-week period and ended when two participants from both stakeholder groups agreed to participate. In total four participants were included in this study.

The participating practice owners are both female, had no previous experience in supervising students and had been working as practice owners for 5 and 10 years. Professional

experience as an educational programme director varied between 22 and 37 years (Tables 1 and 2, below).

Table 1: Overview of interview length and socio-demographic data of the educational programme director (D1 and D2) and institutional conditions of the school.

Participant	D1	D2
Interview length	105:34 minutes	41:14 minutes
Gender	Male	Male
Experience	22 years	32 years
Training capacity	1 course annually	2-3 courses annually

Table 2: Overview of interview length as well as socio-demographic data of practice owners and institutional data of the private physiotherapy practices (P1 and P2).

Participant	P1	P2
Interview length	44:57 minutes	34:33 minutes
Gender	Female	Female
Experience	5 years	20 years
Training capacity	2	6

Data collection

Problem-centred interviews were conducted to explore the subjective approach to the challenge of integrating clinical education in private physiotherapy practice, by stimulating narratives in a semi-structured way (Witzel, 2000). Two interview guides were developed to address the different perspectives of the interview partners (Appendices 1 and 2). In particular, the interview guide for the practice owners sets a biographical narrative stimulus, in which recourse is made to one's own experiences as a professional beginner in private practice. The aim of this consideration was to better understand the key issue on the basis of one's own biography. In the further course of the interview, a transition is made to the role of the practice owner in the present.

The interviews were conducted by the first author. The interview location was chosen by the participants, who all preferred to be interviewed at their workplace. Prior to the beginning of each interview, the intention of the research was explained, and participants were offered the opportunity to ask questions. Informed consent was achieved on the permission to audiorecord the interviews and analyse and report the data after anonymisation. The interviews were audio recorded and lasted between 35 and 105 minutes.

Data analysis

The interviews were analysed using thematic analysis, which is characterised by its independence from epistemological and theoretical positions (Braun & Clarke, 2006). Although the analysis was primarily carried out by the first author, interim results and interpretation were discussed with the co-author to obtain intersubjectively agreeable results. Despite its methodological proximity to grounded theory, thematic analysis excludes theory formation. This enables the data to be evaluated flexibly. Thematic analysis attempts to interpret data profoundly, rather than taking a descriptive approach. The evaluation process includes a recursive six-phase method, which includes constant movement back and forth in the analysis of the data set. Before the process begins, it is necessary to make several preliminary decisions, such as regarding the level of detail of the coding process, for example. In this study, the entire data was coded. In this study an inductive approach was chosen, meaning that no prior coding frame existed. Themes and patterns in the data are identified on an explicit and interpretative level.

In the first phase, “familiarising yourself with the data”, the interviews were transcribed verbatim by the first author. Reading the transcripts repeatedly enables the author to identify initial group-specific thinking trends on a semantic level. The second phase, “generating initial codes”, involves a first manual coding of the initial data set. The transcribed interview data was coded openly line for line to produce data-driven codes. In a second stage, sub-codes emerged, related to the main code. In phase three, “searching for themes”, the codes were considered analytically. By sorting the group-specific codes, cross-group themes emerged from the data set. In phase four, “reviewing themes”, it was checked whether topics could be deduced by their codes. The aim was to find a coherent pattern between codes and themes. In the first-place individual themes were set in relation to the whole data set. A new thematic map emerged, which shows themes, related sub-themes and codes. In the fifth phase of the process, “defining and naming themes”, all themes were provided with clear definitions which prevent overlapping of the topics. Hence, a further specification of the topics is necessary to analyse in-depth the key aspects. The overall aim of this phase is to integrate the topic together with its associated sub-topics into the overall context of the evaluation. The sixth phase, "present results of the analysis", contains a final analysis as well as a formulated presentation of the results as done in this paper.

Ethics considerations

This study was planned and conducted as a Master's thesis at the University of Applied Sciences in Muenster, Germany. There was no ethical approval obtained for that study. The study was based on the guideline for safeguarding good scientific practice of the German Research Foundation, which includes obtaining

informed consent and basing the study on voluntary participation and anonymity.

Findings

Based on the thematic analysis, the results of this study will be presented according to the research question in presenting barriers, advantages and potential for the integration of clinical education in private practices.

Barriers

Economic, legal and institutional framework conditions have an inhibiting influence on the collaboration of physiotherapy education and physiotherapy primary care service settings. These conditions are described from both stakeholder perspectives.

Economic conditions of the private physiotherapy practice setting

As one director of an educational programme mentions, schools have a great interest in initiating collaboration between learning locations.

We have tried this, but it has always met with rejection for all the reasons. It is the time factor and it is the financial factor. (D 2)

He points out that he continuously tries to initiate collaboration between learning locations. So far with little success, since time and financial resources are very limited in private practice. Thus, the economic framework conditions of private physiotherapy practices represent the main barrier to clinical education in this practice setting. The other director of an educational programme also takes up this argument:

We are talking about a physiotherapy scenario, I believe average earnings in practices amount to 2200 euros. To invest in training besides the economic pressure is not legitimate, that is unfair. (D 1)

At this point, there is indignation at even considering activities as a clinical education site in the private practice setting, as it is regarded as inadmissible and illegal in the course of the economic burden, which is also expressed in low earning opportunities. In the following quotation, a director of an educational programme clarifies the direct connection between the low reimbursement by the health insurance company the scarcely calculated treatment frequencies. This shows that physiotherapy practice has a high economic dependency ratio. The economic dependency ratio is presumably responsible for the lack of capacity in private physiotherapy practices.

The reason is undoubtedly that time management prevails in the practices for the time being, which is so close to the limit. This means that due to the low reimbursement of physiotherapy services, one can see that more and more practices treat at 15 to 25-minute intervals. Simply to be able to absorb the financial burden. (D 2)

The practice owner makes clear that student instruction is apparently associated with disrupting the fragile treatment rhythm, with the consequence that subsequent treatments must be postponed. It is probably impossible to provide adequate guidance to students within tightly calculated treatment windows.

So, if I am an intern in the clinic, then I still have a hallway across the corridor where I can prepare something or follow up. I don't have that here. I cannot say between the patients, we have just seen Mrs. A, now we are going to Mrs. B. Now you have just seen that. (P 2)

In the last quote, the practice owner assumes that students can be more easily integrated into the organisational structure of the inpatient setting, since there is less time pressure and apparently more self-determination through variable planning of treatments. This is not possible within a high temporal frequency of patients in the private practice setting which leads to a maximum of external determination. Educational activities which promote the development of the students` competencies cannot be combined with a high frequency of treatment cycles. There is not enough time between treatments for a brief exchange between students and practice instructors. Clinical placements prove to be problematic in this context, as they are accompanied by pre- and post-treatment discussions.

Legal requirements

In addition to the already scarce time and personnel resources, the framework contracts of the health insurance funds must be considered which demand the immediate presence of a certified physiotherapist during student treatments. In contrast to hospitals where students treat independently, these framework agreements in private practices provide one-to-one care for students.

Yes, the main reason is, I believe, the framework agreements with the health insurance funds, which make it difficult for the practice operator. (P 1)

There must always be someone in the room and that is, I think, a (...) yes, a problem. (P 1)

The remarks of a practice owner suggest that feelings of unjust treatment due to underlying legal conditions act as a barrier to collaboration in educational and practice settings. While the economic situation of the hospitals is improved by student work the practice owners have to invest time and personnel in the student instruction. Thus, students worsen the economic situation of the private practice:

After all, hospitals benefit if they take students. They have x-unpaid physiotherapists. The framework agreements are

different. There the students may treat independently. This is not the case in private practice. (P 1)

Training regulations with regard to training in private practice

One programme director considers the requirements of the training regulations to be extremely unfortunate. Specifically, the quantitative requirements of the training regulations are seen as a particular obstacle to practical training in the private practice setting. The specification for clinical education by law includes a certain amount of hours for the medical specialities, such as internal medicine or orthopaedics, can hardly be met in private practice, since there is a wide range of patients in private practices.[1] The first quote questions the overriding meaning of the traditional and rigid specification, which are only marginally consistent with practical training in private practices. This is considered unfortunate by both a programme director and a practice owner:

Why are there such specifications? Why do I have to complete orthopaedics 240 hours? Why can't I go and say, now I'm going to a practice and there I can do orthopaedics, surgery, etc. and don't have to keep a tally list of how many hours I've spent where. (D 2)

When students complete the clinical training in neurology, it also means that they must treat neurological patients as a priority. This can hardly be realized in the private practice. (P 2)

Patients fear reduced quality of care

A programme director who is himself the owner of a private practice fears that many patients will refuse to be treated by a student if they could instead receive treatment by a qualified physiotherapist.

I think fifty percent of my patients would say: no! (D 2)

One private practice owner also sees the problem connection that could arise from the triadic interaction between student, patient and clinical educator and concludes that a direct instruction scenario may prevent patients from feeling well when treated by a student. For the student, this means not being considered a fully-fledged therapist. There is concern that the instruction situation may be perceived as too challenging by the patients. This, however, varies from patient to patient as was expressed elsewhere. The main concern appears to be the fear of practice owners to lose patients should they not feel adequately treated.

Students bring unwanted innovation

Looking after physiotherapy students requires the self-competence to admit to one's own limitations of knowledge. The innovation that students might bring into practice, may not be desired, as a programme director points out, as they put employees under pressure to justify and update their techniques.

And then a student comes along and asks something you've never heard of before, at least that is the fear of many colleagues. (D 2)

It is likely that student support is also associated with the need to break up action routines and question long-standing practice.

Advantages

Practice owners and programme directors associate numerous advantages through engaging in clinical education for their own practice as well as for the profession in general.

Reduced familiarisation time for novices

One practice owner sees the advantage of taking students in the shorter training period for administrative tasks. Normally novices need a lot of help at the start of their career in the private practice setting. One practice owner also positively evaluates the fact that initial contact with the patient clientele of the private practice takes place during the training.

Recruitment of future employees

One practice owner is considering the possibility of recruiting students as potential employees, which is advantageous considering the current lack of skilled labour in Germany. The rising shortage of skilled labour in Germany is increasing the pressure upon private practice owners to attract students as potential employees by providing options for clinical placements.

The shortage of skilled workers is so great that practitioners invest in training, even though it initially means financial losses. (D 1)

Short-term economic disadvantages are apparently accepted in order to have an advantage from a new employee in the long term. This incentive inevitably goes hand in hand with further pressure to create a positive work and learning environment to persuade the student to start working in this practice later.

Less emigration from the profession

One practice owner hopes that the integration of the private practice setting will lead to less emigration from the profession. She associates an increased collaboration with fewer overburdened entrants to the profession. Moreover, clinical instruction is associated with an ease of the workload of current employees which can potentially be considered a form of health promotion and might reduce the level of emigration from the profession.

[1] Physiotherapy training in Germany is structured according to the medical fields of competence, such as internal medicine, orthopaedics, surgery, neurology, paediatrics and gynaecology.

Continued professional development

The practice owners hope that the student's instructions will increase the reflective process of the employed physiotherapists, who are committed to a reflected practice in the sense of a lifelong learning process:

...to make this implicit action explicit as well, this of course becomes even stronger if one also acts as a practice guide. (P 1)

This means not only to apply the knowledge to the patient but also to pass it on to the student. For the patients, this could result in an increased sense of quality which becomes clear in the following quotation:

...because the patients would also be aware that if I am working as a clinical educator that I must then inevitably keep myself up to date, must continue my education, must question myself. (P 1)

However, the proximity of the students to current theories from the classroom is considered less profitable for the professional development of the employees.

I do not get my current knowledge from students. There are enough other sources of knowledge for this. (P 2)

Potentials of collaboration of learning sites

The analysis revealed a total of three potentials for collaboration some of which are linked to concrete conditions. It is striking that there are controversies regarding the potentials within the interviewees.

1. Paid student treatment or paid clinical instruction time.
2. Teachers of the school are responsible for the clinical education.
3. Additional treatments carried out by students.

1. Paid student treatments or paid clinical instruction time

Paid student treatments

To achieve a didactically and methodically valuable collaboration of learning sites, it would be easier for practice owners if student treatments were recognised by the health insurance company. One practice owner emphasises:

There would have to be other contracts with health insurance companies, under which student treatments could be accounted for. (P 1)

Regarding self-responsible student treatments, educational considerations are highlighted. The practice owner states that the competencies of the more senior students who have successfully passed their intermediate exams are fit to work in private practice. (P 1). Within the group of practice owners, disagreements can be identified. One practice owner argues:

This would definitely help, and if this were the case, there would certainly be more collaboration between private practice and schools. But I see a real danger that this would be exploited and that it would not really benefit training. Of course, this would be nice for me as a practice owner, but the question then is, how does a fieldwork placement work - is it then still a matter or training or not? (P 2)

On the one hand, the interviewee points out that the relaxation of this legislation creates incentives for practice holders to participate in practical training. On the other hand, she concludes that these incentives are purely economic in nature, which could potentially be detrimental to the quality of training from an educational point of view. At this point, a critical reflection of the professional group-specific interests becomes apparent.

External funding of student guidance

To achieve a didactically and methodically valuable collaboration of learning sites participants agree that external funding of student supervision is a necessary consequence of the economic conditions predominant in private practices.

I think I can only afford [to] take on students if I am paid for the time the student needs, for example by the health insurance company. (P 2)

Because, there is more to it, it's not purely about treatment time. And by that, I mean something like the follow-up preparation and talk. Otherwise I don't think I could manage it at all. (P 2)

The last quotation from a practice owner reveals that instruction time involves more than the direct treatment time. On the contrary, it includes treatment preparation, formative feedback during treatment and final feedback at the end of treatment. These aspects of clinical education require remuneration since no remedial service is provided here that can be submitted to the health insurance fund. Employed physiotherapists will be able to take on the role of clinical educators if instruction time was remunerated by relevant external institutions.

2. Teachers of the school are responsible for the clinical education

One practice owner has considered making practice rooms and patients become available to schools for educational purposes. The advantage of this is that none of the employed physiotherapists would have to spend any time on instruction, as this is undertaken by the teachers.

Perhaps it could also work in practice by teachers? That would also be an option. Let's say they have an orthopaedic course or teacher and need an orthopaedic placement for students. I could then say, ok, on Wednesday morning, I'll provide the rooms and patients and the teacher, with a couple of students, can treat patients, see what has been done so far, and show or instruct techniques or exercises that are important for the patient. (P 2)

In this quote, the practice owner makes a concrete suggestion for a task assignment. Thus, the teachers of the school are seen in the role of clinical educators, while the organisational setting is provided by the practice owner. Presumably, it is possible for the practice owners to make appointments with the patient, to select patients specifically and to provide rooms.

3. Additional treatment carried out by students
A further possibility is to offer patients additional treatments that may be carried out by a student.

The same goes for the patient, who is said to receive not only his six treatments, but a seventh as well. (P 2)

From a legal point of view, this option raises fewer concerns, since this form of treatment does not create a contractual obligation with the health insurance fund, but rather a private agreement with the patient:

Of course, I can do that in practice. I say, Mrs. A, you have osteoarthritis. I'll treat it, and theoretically, you can have a further two treatments per week. (D 2)

The programme director, who is also the practice owner, describes how the additional treatment can be implemented. For him, it is possible to offer patients additional treatment time which is free of charge and excluded from what is usually covered by the health insurance. A practice owner further states that generous treatment time can be planned; because the student treatment can be separated from the usual time schedule (compare P 2). In addition, it is assumed that many patients would appreciate it (compare P 2). Since economic losses are presumably associated with this variant, a practice owner suggests that student treatment could possibly be rewarded differently (P 2), meaning the patient could pay for the student treatment, but at a lower rate than usually estimated by the health care providers. This could reduce the financial burden which arises from occupied rooms and larger treatment windows.

Discussion

Both practice owners and programme directors judge the current situation for the private setting as deficient for a successful collaboration with physiotherapy education and derive from this the necessity of a modification of the educational training structure. Other studies support this theory. (Baldry Currens & Bithell, 2000; Davies et al., 2011; Dean et al., 2009; Doubt et al., 2004).

The results of this study present physiotherapy educational programme directors and private practice owners' views on the advantages of clinical education of physiotherapy students in the private setting. Participating in practical training as a practice owner means being able to acquire employees at an early stage, as further studies show (Baldry Currens & Bithell, 2000; Doubt et al., 2004; Kent et al., 2015; Sloggett et al., 2003). The early acquisition of students as potential future employees is linked to the most positive impression possible as a potential employer, which could prove to be conducive to high-quality practical training. The acquisition of employees is preceded by the current pressure of skill shortages, which leads to accepting short-term economic disadvantages in order to gain long-term economic benefit from a new workforce.

It can be argued that with a saturation of the labour market practice owners will most likely show less interest in participating in practical training. Davies et al. (2016) support this argument since it is not possible to anticipate in advance whether the student will remain in practice after the training, even though time and money have already been invested in it. Participating in the practical training of students for purely economic reasons may, therefore, be less conducive to a long-term collaboration between learning sites. As the results reveal, the intensified collaboration between learning venues is also associated with a lower level of migration from the workplace, since new entrants to the profession experience a shallow transfer of theory to practice. Davies et al (2016) also discuss this connection. If the practice owners of this study consider the transfer of knowledge by students to be less significant, various studies come to the conclusion that the knowledge base of students represents a resource for further development (Baldry Currens & Bithell, 2000; Davies et al., 2011; Rodger et al., 2008; Sloggett et al., 2003).

The different attitudes of practice owners towards clinical student education internationally and regionally might be explained by the large variation in training structures among different countries (Walkenhorst, 2011). Students, therefore, show adherence to current evidence. The physiotherapy educational training structure in Germany is in part still governed by antiquated structures, since traditional structures of the vocational school system and associated educational training practices are being maintained despite the progressive orientation of physiotherapy training at universities of applied sciences (Walkenhorst, 2013). However, the role of the clinical educator holds the potential for developing professional expertise. This is done by critically reflecting on one's own actions and by explicating implicit knowledge, which is also seen by Sloggett et al (2003) as beneficial for organisational learning. According to Davies et al. (2011), this reflective learning culture (Schön, 2013) also contributes to personal expertise development. As already pointed out by Thompson and Proctor (1990), Sloggett et al. (2003) and Recker-Hughes et al. (2014) the practice owners of this study associate the practical guidance of students with a profile and image building of their clinic.

As long as the economic efficiency of private practices increases in offering shorter treatments (Schiessel, 2013), there is only a little flexibility to integrate students in the predefined processes without incurring financial losses. A consistent synthesis of practical training and student guidance within tightly calculated treatment windows proves to be unrealistic. As the results show, instructing students is directly related to financial losses, which is listed in other studies (Baldry Currens & Bithell, 2000; Davies et al., 2011; Doubt et al., 2004; Kent et al., 2015; Maxwell, 1995;

Moore & Field, 2017; Rodger et al., 2008). Hence, the high costs associated with student guidance seem to be one of the main barriers to participating in practical training, both nationally and internationally. As further studies have shown (Baldry Currens & Bithell, 2000; Davies et al., 2011; Recker-Hughes et al., 2014), taking over a dual role as a provider of the remedy and a practice leader within these framework structures is nearly impossible. Davies et al. (2011) have already stated that practice instructor activities lead to a high-stress load within limited time resources, which is also anticipated by the school directors of this study.

The existing health insurance policy which allows student treatments only under the condition of "permanent supervision", is an additional impediment for practice owners to participate in clinical education. The Australian Physiotherapy Association's National Physiotherapy Service Descriptors (APA, 2012) set almost identical standards. For the interviewed practice owners at Kent et al. (2015), however, an impediment to taking students would only arise if students' treatments under guidance were not remunerated. That is neither the case in Germany nor in Australia. Since the practice owners do not reward the student for his/her treatment, it can be assumed that there will be no loss due to the direct guidance situation. However, a financial loss could be expected if the student needs more time than the practice's treatment rhythm/schedule allows.

Factors that limit collaboration between learning sites are also the requirements of the German Training and Examination Ordinance (PhysTh-APrV,1994). Fixed hourly targets for the medical areas of competence conflict with the unpredictability and non-plannability of patient numbers and the representation of the respective medical area of competence. A precisely fitting allocation is therefore unrealistic, which is something that further studies are taking up (Dean et al., 2009; McMahon et al., 2014). Presumably, physiotherapy schools will not be able to disengage themselves from the traditionally established practical training in Germany, which, against the background of existing studies also proves to be conflictual at the international level (Doubt et al., 2004; McMahon et al., 2013; McMeeken, 2008; Shields et al., 2013; Smith et al., 2013). Seemingly for physiotherapy schools cooperating with care facilities of the inpatient sector is initially a "safer way", since the quantitative guidelines are easier to comply with. As the results show, practice owners fear that many patients refuse treatment by a student, even if an instructing therapist is present, which is also listed by Doubt et al (2004).

To anchor cooperation, it is necessary to modify external framework structures in the first place. The primary concern of the practice owners is to receive remuneration for the period of instruction, which is why a modification of overarching framework conditions is required first. The relaxation of the existing health insurance policy is listed as a prerequisite for cooperation, but this is proving to be a point of discussion within the interview group of practice owners. On the one hand, concerns are raised that the relaxation of the policy creates economic incentives for practice owners. On the other hand, the relaxation of this policy may aggravate valuable cooperation which also considers the pedagogical and didactic interests of the students.

In the context of relaxing the legal requirements of the health insurances, it is suggested to locate the private setting towards the end of the training. It is argued that after this period students already have increased competences to carry out treatments independently. This may also be associated with the fact that students need less help and therefore take up less of the other employees' time. However, Sloggett et al. (2003) point out that there are very high expectations of the student's competences in private practice, which can be linked to the impression that only students who already possess a high degree of social, methodological, technical and personal competence are suitable for a fieldwork placement in private practice. In support of this argument, the inpatient setting must be fundamentally distinguished from the private setting, both in its professional and organisational characteristics (Atkinson & McElroy, 2016; Kent et al., 2015; McMahon et al., 2013; Solomon & Miller, 2003).

Students with learning difficulties who lack critical thinking skills and creativity run the risk of not being able to cope with the complex demands of private practices (Sloggett et al., 2003). Hence, the modification of this change in the law must be viewed critically. If this protective space is not initially granted to the students this may lead to fear and overexertion, as described by Atkinson and McElroy (2016) and Solomon and Miller (2005). Existing health insurance policies in this context secure quality of care and guarantee pedagogical sanctuary. However, it remains questionable whether the relaxation of health insurance policies inevitably contradicts a protective space for students. This seems to be connected to how the private practice weights the student's instruction and anchors it in the practice philosophy.

As Baldry Currens and Bithell (2000) have already pointed out, additional remuneration for the instruction period is a prerequisite for taking on the role of a practical instructor. According to the results of this study, the health insurance funds or the federal state are seen as potential sources of finance. This raises the fundamental question of whether health insurance funds would pay for the remuneration of the educational time since this service is not in their primary responsibility. It may appear paradoxical that the health insurance funds, which are held responsible by the interviewees for the general unfortunate economic situation of private practices, are seen as potential sources of finance. The demand for remuneration from the state can be justified since teaching practices in medicine also receive low financial compensation from faculties (DEGAM & GEHA, 2012).

Within this study, one of the key issues concerns the development of collaboration of learning sites that do not go along with an adaptation of external framework structures. The possibility for practices to provide rooms and patients for teachers and students is accompanied by the fact that students and teachers treat patients together in private practice. In the

triad of student-patient-practice instructors (Klemme, 2012; Plack & Driscoll, 2017), it is therefore not the employees of the physiotherapy practice who provide the practical guidance, but the teachers of the school. It could be an advantage that the temporal rhythm of the practice is not disturbed since treatment by students and teachers can be excluded from the usual treatment rhythm. An advantage for the school organisation is that instruction in small student groups is conceivable. The possibility of offering patients additional treatments provided by students goes along with a previously closed informed consent, as explained by Kent et al. (2015). The advantage of this form of implementation is that care providers are not involved. To include questions that assign to a pedagogical-didactic perspective it might be possible that students and teachers perform additional treatments together. It can be considered critically that the pedagogical contribution to cooperation is either made by the school or does not take place.

Methodological limitations will now be discussed. The small sample of interviews allowed for an increased depth of interpretation but excluded a possible generalisation of the results. The different levels of relevance that became apparent within the interview groups were only taken into account if they were particularly evident since the focus was on cross-group analysis. Possibly existing differences within the interview groups are also connected with the different characteristics of the institutional contexts. Further pre-defined inclusion criteria, which particularly concern the institutional contexts (e.g. only practices with SHI-accredited physicians, practices with a minimum number of rooms or only private schools), could possibly have led to even more precise results. The interviews were conducted in North Rhine-Westphalia. Due to the federal structure of Germany, there are also limitations here, which reduce the transferability of the results.

The interview participants, who were active as programme directors, were already recruited on the basis of anticipated proximity to the problem subject. It is conceivable that other programme directors differ from other programme directors in their subjective view of the problem and depth of reflection. With regard to the interview group of practice owners, it can be assumed that possibly only those who are highly willing to deal with the problem object showed interest. Their subjective problem view might differ from those who were less motivated to participate in the interview. The inclusion of practice owners who already have experience with learning location cooperation could have proved to be profitable for the generation of opportunities. During the preliminary interview, the interviewer revealed her own professional identity as a physiotherapist, so that the professional proximity may have led to not expressing circumstances and contexts that were considered to be presupposed. As this research did not address a vulnerable group an ethical approval was not obtained.

Conclusion and perspectives

Despite high employment in the private sector, the current practical training does not sufficiently prepare future physiotherapists for work in private practice. Therefore, an increased focus on private physiotherapy practice is needed in professional physiotherapy training in Germany. The current gap between practical training and professional work can only be bridged by the increased involvement of private practices in practical training.

In this article, we have outlined advantages, barriers and potentials of collaboration between private practice and schools of physiotherapy. In the current situation of a shortage of skilled workers, the advantages of cooperation between learning venues for practice owners are that they can acquire employees at an early stage, there is less need for induction of newcomers to the profession, and there is less migration from the profession. The main barriers to cooperation are the economic resources of private practice which contradict the time-intensive student support. The conceived potentials aim at saving time and personnel resources of the private practices so that there are no financial disadvantages linked to student support. Increased participation of private practices in practical training must include a modification of external framework structures, aimed at a remuneration of the instruction time. To validate these potentials, it is necessary to develop research projects that evaluate the feasibility and the use of different options. Thus, further studies should include the perspectives of health insurance companies and politicians as well as the patient perspective.

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