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Interprofessional and Multidisciplinary Health Student Clinic Implementation in Australia and New Zealand

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Abstract

Interprofessional and multidisciplinary student clinics aim to prepare the future workforce for collaborative care. The aim of this study was to gain a situational overview of the distribution and models of interprofessional and multidisciplinary student clinics in Australian and New Zealand universities. An online survey, delivered via a secure web application, captured responses from 14 health science deans from 12 universities and 65 clinical supervisors from 28 universities. Clinic models varied widely from single- or multi-discipline to interprofessional approaches. Over half of universities had multidisciplinary student clinics and 39% implemented interprofessional models. Over half were in metropolitan regions. Thematic analysis of clinical supervisor responses showed that adoption of interprofessional clinics can be limited by resource constraints, timetabling, and variations in pedagogical models. Many supervisors demonstrated readiness and intention to offer interprofessional learning. Overall, this study highlighted the need to develop sustainable models for interprofessional student clinics to optimise shared learning and collaborative practice.

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Practitioner Notes

1. Implement interprofessional clinical placement opportunities that prepare future graduates for collaborative, patient-centred healthcare practice.
2. Design activities in multidisciplinary student clinics that encourage students from various disciplines to engage and collaborate.
3. Inform key stakeholders about interprofessional education and its benefits to support engagement with interprofessional practice.
4. Seek academic-community clinical education partnerships to maximise opportunities for interprofessional education and practice.
5. Collaborate with key clinical placement stakeholders in the co-design of student projects and services to enhance student and patient outcomes.

Keywords

health professional student, clinical education, interprofessional practice, healthcare team, student clinic

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Introduction

To prepare the future health workforce, interprofessional and multidisciplinary student clinics for health professional students are increasingly being implemented across the world (Davison et al., 2024; Hulme et al., 2024; Jensen et al., 2023; O'Leary et al., 2020). University students often first experience interprofessional healthcare through clinical education placements, including student clinics (Kent et al., 2018). Student clinics can be classified as student-led, student-run or student-assisted and are a form of clinical placement where students can work closely together to deliver healthcare services to clients under the supervision of registered professionals (Forbes et al., 2021). They aim to bridge the gap between higher education and employment in healthcare settings by exposing students to practice in a real-world setting (Brewer et al., 2024; O'Leary et al., 2020).

Operational models of student clinics vary widely and may be broadly separated into interprofessional, multidisciplinary or single discipline. In an interprofessional clinic, students from two or more professions learn with, from and about each other to deliver care to clients (World Health Organization, 2010). In multidisciplinary clinics, students from different professions work alongside one another but tend to make clinical decisions and deliver services independently (Hero & Lindfors, 2019). Single-discipline clinics are a common model where students develop profession-specific skills (Tokolahi et al., 2021). This study focuses on interprofessional and multidisciplinary clinics.

The extent to which Australian and New Zealand universities use interprofessional and multidisciplinary health student clinics as part of their clinical education programs is currently unclear. The pedagogical models and methods that universities use for implementing health student clinics are also poorly understood. We were particularly interested in the extent to which health student clinics were interprofessional because this model of clinical education has been linked to high-quality patient care and workforce-ready graduates (Bogossian et al., 2023; Neubauer et al., 2024).

The overall objective of the current study was to gain a situational overview of the distribution, extent and operational models for interprofessional and multidisciplinary student clinics in Australian and New Zealand universities. Specifically, this cross-sectional survey addresses the following research questions:

1. Which Australian and New Zealand universities offer interprofessional or multidisciplinary health student clinics as clinical placement sites?
2. What are the characteristics of interprofessional and multidisciplinary student clinics in Australia and New Zealand, including operational models, healthcare services delivered, participating patients and students, clinical educator supervisory models and use of co-design practices in student clinic implementation?

This study contributes to the field by clarifying how interprofessional student clinics are currently implemented and where sustainable models may be needed. Although extensive evidence supports embedding interprofessional education in university curricula, its implementation within real-world clinical education models remains poorly described.

Literature

Clinical Education and the Move Towards Interprofessional Learning

Clinical education for health professional students has traditionally been delivered using single discipline modes of teaching and learning (Bogossian & Craven, 2021). Learning activities within clinical education have also mainly focused on the needs of specific disciplines such as nursing, midwifery, medicine, physiotherapy, occupational therapy and speech pathology (Skinner et al. 2025; van Diggele et al., 2022). Some argue that single discipline health student education does not adequately foster interprofessional collaboration, even though it increases student knowledge and competency for service delivery in individual disciplines (Bogossian & Craven, 2021). Patient care and student learning can be adversely affected when the professional discipline is the focus rather than client-centred care (Fernandopulle, 2021; Prestes Vargas et al., 2025). Contemporary health student education frameworks and guidance (e.g., Ford & Gray, 2021; Dunston et al., 2020; Ferreira et al., 2024; WHO, 2010) also emphasise the value of collaborative student learning and interprofessional practice for health professional students, to optimise teamwork, care quality and student learning outcomes (Guinat et al., 2025; He et al., 2024).

Interprofessional and Multidisciplinary Education

Interprofessional education has been defined as occasions when two or more individuals from distinct disciplines learn from and about each other through collaboration (Barr, 2002; WHO & UNICEF, 2018). Interprofessional education is intended as a precursor to Interprofessional Collaborative Practice (IPCP) among the health workforce, where team members share similar patient-centred goals (Mohammed et al., 2021). In contrast, in multidisciplinary learning each discipline maintains its own perspective and treatment approach whilst contributing to patient care (van Diggele et al., 2020). Multidisciplinary clinics are often used to educate health professional students, yet they sometimes rely on incidental opportunities for student collaboration across disciplines rather than structured interprofessional learning (Walker, 2023).

Student Clinic Models, Benefits and Challenges

A range of student clinic models have been reported, as summarised in a recent scoping review (Prestes Vargas et al., 2025). They include university clinics on campus (Copley et al., 2007), student-run or free clinics in community settings (Huang et al., 2021), short-term clinical projects run by students (Howell et al., 2021), and student education embedded in hospitals (Ericson et al., 2017), residential aged care (Kent et al., 2014) or community centres (Sargison et al., 2021).

Health student clinics can have benefits and challenges in implementation according to the patient populations served (Burgess & Roberts, 2022), the geographic regions where they are based (Walker et al., 2022) and university curricula models for health professional student education (Sargison et al., 2021). Reported benefits of interprofessional models include improved student confidence and knowledge of roles (Hopkins et al., 2022), improved patient outcomes (Broman et al., 2022), better patient access to comprehensive care (George et al., 2017) and greater health care workforce sustainability (Nagelkerk et al., 2021). Nevertheless, there can be challenges in implementing interprofessional clinics, such as difficulties coordinating schedules, funding constraints, and ensuring consistent engagement from stakeholders across different disciplines (Collis et al., 2024). Much of this evidence comes from single-site descriptions (Ng & Hu, 2017;

Briggs & Fronek, 2024), and little is known about how clinics are distributed or structured in Australia and New Zealand.

Theoretical Frameworks

Interprofessional student clinics often anchor their design in established frameworks to intentionally structure their educational environments (Hopkins et al., 2022; Lie et al., 2016). Reported examples include the Canadian Interprofessional Health Collaborative competency framework (CIHC, 2010), Interprofessional Education Collaborative Core Competencies (IPEC, 2023), and Curtin University's Interprofessional Capability Framework (Brewer & Jones, 2013). These frameworks translate the WHO's (2010) call for collaborative practice into the skills students are expected to develop during clinical placement. Together, these provide a shared language and learning guidelines that keep the educational purpose of the clinic central.

Existing literature offers valuable guidance on implementing interprofessional education as mentioned above, but most of it focuses on classroom-based learning or simulation rather than clinical education with real clients where the student leads service delivery. Where clinical placements are described, single-discipline or multidisciplinary models predominate, possibly due to the recognised barriers to implementing truly interprofessional models (Collis et al., 2024; Prestes Vargas et al., 2025). By mapping current clinical education practice across Australia and New Zealand, this study provides a baseline to inform the development of interprofessional student clinics.

Method

Research Design

Ethical approval was obtained from the La Trobe Human Research Ethics Committee for the two different surveys: one survey involved health sciences deans (HEC23503), and the other involved clinical supervisors (HEC24214). Informed consent was obtained via the secure web application for building and managing online surveys, REDCap (Harris et al., 2009). Participation was voluntary, responses were de-identified prior to analysis, and data were collected, managed, and reported in accordance with recognised principles of confidentiality, participant welfare, and responsible research conduct (Purvis & Crawford, 2024).

This study employed a cross-sectional survey methodology (Ayton et al., 2023; Liamputtong, 2020) to gather quantitative and qualitative data on the characteristics and locations of interprofessional and multidisciplinary health student clinics in Australia and New Zealand. To inform survey design, we integrated data from our previous scoping review (Prestes Vargas et al., 2025), which explored the feasibility and implementation of interprofessional student clinics worldwide. Additionally, we incorporated published literature on the perspectives of health professional academics involved in student clinical education (Fröberg et al., 2018; O'Leary & Guinan, 2022; Romig et al., 2017). The research team (JPV, MS, CP, MM) refined the surveys through collaborative discussions, drawing on their collective clinical and research expertise to ensure the questions were relevant, evidence-based, and practically meaningful.

Participants

Two participant groups were included in this study: health sciences deans and clinical supervisors involved in university-based health student clinics in Australia and New Zealand.

Health Sciences Deans

Health sciences deans from universities offering programmes in medicine, nursing, dentistry, allied health, and social care were invited to participate. Deans were selected because they typically hold oversight of health professional education programmes and were therefore well positioned to identify the existence of health student clinics within their institutions and provide information about their broad characteristics. Invitations to participate were emailed to 75 health sciences deans (61 in Australia and 14 in New Zealand) between February and November 2024, with two reminder invitations distributed during the recruitment period.

Clinical Supervisors

Clinical supervisors involved in interprofessional or multidisciplinary health student clinics at Australian and New Zealand universities were invited to participate. Clinical supervisors were selected because of their direct involvement in the day-to-day operation of student clinics and their ability to provide detailed information about clinic models, service delivery, supervision practices, and operational processes. A clinical supervisor is a senior professional who guides junior staff or students to enhance their skills and safeguard service quality (Terry et al., 2020a). Invitations to participate were emailed to 207 clinical supervisors between June 2024 and February 2025, with two reminder invitations distributed during the recruitment period. The study focused on interprofessional and multidisciplinary student clinics. Single-discipline student clinics were excluded from the primary focus of the study because interprofessional education is founded on collaborative learning and practice involving two or more disciplines (Barr, 2002).

Measures

Two survey instruments were developed for this study. The dean survey comprised three questions designed to identify whether universities operated health professional student clinics, the number of clinics, and the disciplines involved. The survey also asked deans whether clinics operated using interprofessional, single-discipline, and student-led models.

The clinical supervisor survey comprised 35 questions examining five broad domains: (i) clinic operational models, (ii) services provided, (iii) student characteristics and roles, (iv) clinical supervisor characteristics and supervision practices, and (v) clinic location. Questions included yes/no items, single- and multiple-response questions, and optional free-text comment boxes. Together, these measures were designed to address the study aims of identifying the distribution, characteristics, and operational features of interprofessional and multidisciplinary student clinics across Australia and New Zealand. Both surveys were informed by findings from a previous scoping review (Prestes Vargas et al., 2025) and relevant literature on health professional education (Fröberg et al., 2018; O'Leary & Guinan, 2022; Romig et al., 2017).

Procedure

A two-stage process was used to gather survey data. The first step was to send a survey to deans of health sciences in Australian and New Zealand universities (medicine, nursing, dental, allied health and social care). Deans were identified via university websites and professional networks. The second step was to send a survey to clinical supervisors participating in interprofessional or multidisciplinary student clinics in Australia and New Zealand universities. Clinical supervisors were identified via the deans, university or student clinic websites and professional networks. We did not focus on single-discipline health student clinics because the basis of interprofessional education lies in the collaborative efforts between two or more disciplines (Barr, 2002). Study data were collected and managed using the Research Electronic Data Capture (REDCap) electronic data capture tool hosted at our university. REDCap is a secure, web-based platform for research data collection, offering validated data capture, audit trails, automated data export, and integration with external systems (Harris et al., 2019; Harris et al., 2009).

Analysis

Quantitative data and free-text comments were exported from REDCap to a Microsoft Excel file, cleaned, and analysed. To characterise the sample, we used descriptive statistics including frequencies and percentages for categorical variables such as the types of services delivered by students, student demographics and clinical supervisor characteristics. For ordinal variables, such as the number of university clinics per operational model collected in the dean survey, we calculated the range and interquartile range (IQR) to capture data dispersion. The range provided a measure of overall spread, while the IQR captured variability without undue influence of extreme values (Salmond, 2007). Survey responses were complete, and no data were excluded due to missing values.

Qualitative data (free text survey responses) were optional and were analysed descriptively to complement survey data. Data were coded and analysed thematically using an inductive approach to enable emergence of themes from the bottom up (Braun & Clarke, 2021). For this qualitative analysis, two researchers (JPV, MS) independently generated initial codes before meeting to discuss areas of similarity and difference. Codes were subsequently grouped into candidate themes, which were reviewed, refined, and agreed upon through discussion. Themes were then defined and named to reflect the dominant patterns across the data (Braun & Clarke, 2021).

The analysis was informed by the research team's backgrounds in health professional education and clinical supervision. JPV is a physiotherapist and PhD candidate whose doctoral research examines interprofessional student clinics, and MS is an academic and researcher in the fields of neurological rehabilitation and clinical education. We approached the data with the view that well-structured interprofessional clinics may offer benefits to stakeholders, recognising that this perspective could influence our interpretation of participants' accounts. Our experience in clinical supervision may also have shaped how we interpreted descriptions of supervisory models. To limit the influence of these assumptions, we engaged in reflexive memoing and regular analytic discussions.

Results

A total of 79 people responded, including 14 university deans and 65 clinical supervisors from Australia and New Zealand. Nine deans from Australia and five from New Zealand participated, representing 12 universities. Table 1 shows that nine deans advised that their universities ran interprofessional health student clinics. Twelve deans advised their universities operated single-discipline student clinics in fields such as dietetics, exercise physiology, physiotherapy and psychology (Table 1). Deans reported that eight universities had student-led clinics. Five of the student-led clinics were single-discipline clinics, and three were interprofessional clinics (Table 1). Student-led clinics refer to a model of clinical education where students enrolled in clinical placement progressively lead service delivery in a real-life setting while being supervised by a registered clinician (Bostick et al., 2014; Broman et al., 2022).

Table 1

Summary of Clinic Models

Question	Responded 'yes'	Number of clinics Range (IQR)	Student clinic disciplines
Does your organisation currently run any interprofessional student clinics?	9	1-5 (1)	Audiology, Chiropractic, Counselling/Psychotherapy, Dietetics, Exercise and Sports Science, Exercise Physiology, Nursing, Nutrition, Pharmacy, Occupational Therapy, Optometry, Oral Health, Paramedicine, Medicine, Physiotherapy, Podiatry, Psychology, Social Work, Speech Pathology
Does your organisation currently run any single-discipline student clinics?	12	1-12 (3)	Audiology, Chiropractic, Dermal Science, Dietetics, Exercise Physiology, Nursing, Nutrition, Pharmacy, Optometry, Osteopathy, Medicine, Physiotherapy, Podiatry, Psychology, Social Work, Speech Pathology
Does your organisation currently run any student-led clinics (single discipline)	5	1-5 (3)	Chiropractic, Dermal Science, Dietetics, Exercise Physiology, Optometry, Osteopathy, Podiatry, Psychology
Does your organisation currently run any student-led clinics (interprofessional)	3	0-2 (1)	Counselling/Psychotherapy, Dietetics, Exercise Physiology, Nutrition, Occupational Therapy, Oral Health, Physiotherapy, Podiatry, Psychology, Social Work, Speech Pathology

Some (n=4) of the university deans provided comments on the level of interprofessional interaction and clinic operational models at their universities. The comments related to clinics not being truly interprofessional or student-led, stating that many students worked mostly independently within their field and were not involved in the design or organisation of patient services. Interprofessional student clinics were noted by some of the deans to have potential, yet there were challenges in administration. In the words of one of the deans, there was "huge

potential for interprofessional student clinics. But administratively high workload and challenge of running health services within tertiary education institution semesters and continuity of care." (ID 12).

Sixty-five clinical supervisors from Australian and New Zealand universities responded to the online clinical supervisor survey. They represented 34 student clinics in Australia and four in New Zealand from the 28 universities that responded. Seven dean responses (58%) overlapped with clinical supervisor responses. The characteristics of health professional student clinics reported by clinical supervisors are summarised in Table 2. These included services delivered by students, such as screening and assessment, client/patient education, treatment, referrals, social care and welfare, medication review, medication or supplement prescription and vaccination. Treatments typically included exercises, manual therapies, medical, dental or mental health interventions (Table 2).

Table 2

Characteristics of Health Professional Student Clinics

Student clinic characteristic	**Frequency***	**%***
No. of clinical supervisor respondents	65	
No. of student clinics	38	
Model of clinic operation		
Single discipline	12	19
Multidisciplinary	36	53
Interprofessional	24	39
Interventions delivered by students		
Screening and assessment	59	91
Client education	58	89
Treatment	52	80
Referrals	29	45
Social care, welfare	13	20
Medication review	5	8
Medication prescription	3	5
Vaccination	2	3
Mode of intervention delivery		
Individual clinical session – 1 discipline	56	86
Individual clinical session – 2 or more disciplines	25	38
Group session – 1 discipline	31	48
Group session – 2 or more disciplines	15	23
Most common client disease groups		
Musculoskeletal and sporting injuries	26	40
Chronic diseases	21	32
Neurological disorders	17	26
Falls	12	18
Mental illnesses	11	17
Paediatrics	10	15
Persistent pain	9	14
Geriatric or palliative care, and metabolic disorders	8	12
Reconditioning, frailty, speech disorders	7	11

Client age groups		
0-5	11	17
6-12	16	25
13-19	17	26
20-24	29	45
25-64	49	75
+65	44	68
Main sources of referrals		
Self-referrals/walk-ins	51	82
General practitioners	35	56
Allied health professionals	29	47
Medical specialists	15	24
Educational professionals	9	15
Fee structure		
Payment required	47	73
Free and subsidised services	36	56
Clinic operational days		
Monday to Friday	37	57
4 days per week	13	20
<4 days per week	15	23
Groups involved in clinic co-design		
Clinical supervisors	23	35
Academic team	21	32
Clinic managers	16	25
Students	14	22
Clients/family members	8	12
Student affiliation to the clinic		
Mandatory clinical placement	54	83
Elective clinical placement	11	17
Student volunteer	6	9

*Frequencies and percentages are based on the number of clinical supervisor respondents.

Operational Models

More than half of clinical supervisors (n=36/65) indicated that health student clinics functioned within a multidisciplinary model of clinical education, while 24 advised that clinics were interprofessional (Table 3). Although eligibility required student clinics to provide interprofessional learning opportunities, 12 supervisors described their clinic operational model as single discipline. These clinics typically involved students from one profession delivering clinical services independently, with interprofessional exposure occurring through activities such as joint case conferences or shared in-services. Most services were delivered by a single discipline via individual patient (86%) or group clinical sessions (48%) (Table 2). Interprofessional clinical sessions delivered by students from two or more disciplines were less frequent and were delivered to an individual patient (38%) or to a group of patients (23%) (Table 2).

Table 3

Participating Universities and Their Clinic Operational Models in 2024-2025

Universities	Single discipline	Multi-disciplinary	Inter-professional	No clinics reported
Auckland University of Technology		x		
Australian Catholic University		x		
Australian National University			x	
Bond University		x	x	
Central Queensland University		x	x	
Charles Darwin University	x			
Curtin University		x	x	
Edith Cowan University		x		
Federation University	x			
Flinders University	x		x	
Griffith University		x	x	
James Cook University		x	x	
La Trobe University	x	x		
Macquarie University	x		x	
Massey University			x	
Monash University			x	
Queensland University of Technology			x	
RMIT University		x		
Southern Cross University	x	x		
Swinburne University of Technology	x			
The University of Melbourne	x		x	
The University of Queensland			x	
Torrens University		x		
University of Adelaide				x
University of Auckland		x	x	
University of Canberra		x	x	
University of Canterbury	x		x	
University of Otago	x		x	
University of South Australia		x	x	
University of Southern Queensland		x		
University of the Sunshine Coast		x	x	
Victoria University			x	
Western Sydney University		x		

Twenty-one clinical supervisors provided free text comments related to the clinic's operational model and general comments at the end of survey. Qualitative analysis of clinical supervisor comments identified two key themes, namely Operational challenges in implementing interprofessional health student clinics (Theme 1) and Variability in models of health student clinic delivery (Theme 2). Exemplar quotations are provided to illustrate each theme (Table 4). In theme 1, clinical supervisors highlighted several challenges in implementing interprofessional health student clinics, including scheduling conflicts between different programmes and limited student availability, which often resulted in clinics being more multidisciplinary rather than truly interprofessional. Despite the intent to work interprofessionally, consistent collaboration across disciplines often remained difficult to achieve in practice due to logistical issues and the need for better integration of clinics.

Table 4

Themes on Health Student Clinic Education From Clinical Supervisors

Theme	Definition	Example responses
Operational challenges in implementing interprofessional health student clinics	Practical constraints, such as student availability and timetabling, that limit interprofessional delivery, leaving clinics operating under a multidisciplinary model or still working towards interprofessional practice.	Sometimes, due to the schedules of the different programmes, it becomes more multidisciplinary, e.g., for our remote clients (ID 62)
		Unfortunately, the Speech Pathology clinic is not involved in the IP clinic due to student availability (student only attend x4 hours per week across 10 weeks). (ID 25)
		Attempted SPOT [Speech Pathology and Occupational Therapy] clinic in the past, however, due to student availability this was unable to be continued (i.e., speech clinic only operating 4hrs a week which didn't align to OT hours). (ID 25)
		We have been established as an "interprofessional" clinic and there is always an intent to work inter-professionally. There may be occasional moments of interprofessional collaboration but this is not common practice in our clinic. In my opinion we have never really managed to make it work in practice. (ID 64)
		Although the clinic itself is IPE, at [clinic] we have not yet been able to integrate our clinics although this is a goal. So please note (again) that my responses have been for my experience in the [discipline] at [clinic], and not for the [clinic] as a whole. (ID 31)
		Currently multi-disciplinary, working towards interprofessional. (ID 52)
		Currently multi-disc. Aiming to work towards Interprofessional (ID 5)
		There have not been as many opportunities for interprofessional work as I would like. There are a number of different reasons for this. (ID 27)

Variability in models of health student clinic delivery	The range of arrangements for how disciplines work together, from co-located separate clinics to partially integrated delivery, and differences in supervision.	At this time, there is one interprofessional clinic delivering a 12-week group program. The remaining clinics are currently operating separately, however in the same physical space. (ID 46)
		Within [clinic] are several different clinics (audiology, speech pathology, optometry etc). We have our own physical space, see our own patients. The only commonality is the senior management team. (ID 45)
		The clinic works in different ways in different spaces. Although there are different disciplinary clinics working in the above way - OT in [clinic] actually works outside this model. Please note that although they may work different in the [other clinic branch], my responses reflect how we are currently working in [clinic]. (ID 31)
		We have some overlap between disciplines e.g., SPOT services (speech and occupational therapy) delivered to the same client at the same time and other days it is one service delivery at a time. Screeners/assessments are completed separately. Some notes are completed together though most in separate disciplines. (ID 35)
		While assessments are generally discipline specific, students engage in joint sessions working towards common goals. (ID 42)
		The student-led clinic also involves some interprofessional education aspects. These occur every morning prior to the start of the day. Topics include role clarity, team functioning, patient centred care, communication (all as per the Canadian framework for interprofessional practice) as well as discipline specific topics such as trauma informed care, body composition, midwifery (e.g., breastfeeding and post-partum exercise), role of a speech pathologist and suicide risk screening. (ID 47)
		Can be interprofessional at times. (ID 15)
		[Clinic] occur as ad hoc events. No ongoing care, just at one time point. (ID 33)
		This clinic runs a variety of placements. Some are community based, clinic campus based, hospital based, private, etc. A range of service models are used across these placements. (ID 63)
		Being a rural healthcare service students who are not EP or Nursing students receive remote supervision from clinical educators in our [clinic] office. (ID 48)

In theme 2, clinical supervisors reported variability in the delivery models of health student clinics, with some clinics being interprofessional at times, while others remained mostly discipline-specific but shared physical spaces. Additionally, the clinics employed a range of service models, including community-based, campus-based, hospital-based, university-industry partnerships and ad hoc clinics, with varying degrees of interdisciplinary collaboration and student autonomy. Some

clinics also incorporated education sessions to enhance interprofessional competencies such as role clarity, team functioning, and patient-centred care. Supervision was sometimes delivered remotely. Efforts were being made to incorporate interprofessional education through structured activities, but the degree of integration remained inconsistent across different clinic settings (Table 4).

Collaboration in Health Professional Student Clinics

Thirty-nine of the clinical supervisors indicated that students collaborated in clinical tasks 'sometimes'. Six responded that students 'always' worked collaboratively, and 20 reported that students from different disciplines 'never' worked together. The opportunities for teamwork included case conferences (n=42), post-clinical session debriefs (n=34), pre-clinical session planning and rounds (n=30), and individual client clinical sessions with students from two or more disciplines, or a joint session (n=25). Other opportunities included group supervision, group reflections, informal group discussions, interprofessional education sessions and joint case studies.

Student Orientation to Clinic Tasks

All clinical supervisors reported that students received formal orientation and an induction session prior to starting clinical placement. The most frequent forms of orientation included face-to-face induction on the first day of placement delivered by the clinical supervisors (n=44), clinic handbooks and online modules (n=18), formal lectures (n=4), a general orientation delivered by clinic administrators (n=4), student-led orientation (n=3), or simulation-based education (n=2).

Health Disciplines Represented in Student Clinics

Table 5 presents the health disciplines reported for health professional student clinics, and the disciplines represented in interprofessional settings. The disciplines with the highest representation of interprofessional clinics were Occupational Therapy and Physiotherapy (24.2% each), followed by Dietetics and Exercise Physiology (19.4% each). Other disciplines such as Psychology (21.0%), Nursing (17.7%), and Speech Pathology (14.5%) also had a significant representation. Several disciplines, including Orthoptics, Orthotics/Prosthetics and Osteopathy, were not represented in interprofessional student clinics in the current survey.

Student Autonomy

Most supervisors reported clinics to have some components that were 'student-led' (n=45/65). This means that students were involved in delivering healthcare services under the supervision of a registered clinician and may have been involved in leadership and administrative-related tasks such as clinic or service design, answering the clinic phone and booking clients. Some clinics were considered to be a 'standard block type clinical placement' (n=19/65), 'student assisted' (n=15/65) or 'student run' (n=10/54). Seven clinical supervisors said that clinics were delivered using project-based clinical placements, where the clinic functions intermittently according to seasonal projects. Four described clinics as service-learning, which uses a "learn by doing" model (Kolb & Kolb, 2005). A third of clinical supervisors selected two or more descriptive clinic terms (e.g., student-led, student-run, student-assisted, service-learning, project-based clinical placement and standard 'block' clinical placement).

Table 5

Healthcare Services Offered at Participating Student Clinics

Health discipline	Number of respondents who selected this discipline	% of respondents who indicated interprofessional clinics
Audiology	4	1.6
Chinese medicine	5	0
Chiropractic	5	1.6
Counselling/ psychotherapy	17	8.1
Dentistry	2	0
Diabetes education	3	4.8
Dietetics	20	19.4
Exercise and sport science	1	1.6
Exercise physiology	25	19.4
Medicine	3	4.8
Midwifery	5	3.2
Music therapy	1	0
Naturopathy	2	0
Nursing	11	17.7
Nutrition	15	11.3
Occupational therapy	25	24.2
Optometry	9	8.1
Oral health	1	1.6
Orthoptics	2	0
Orthotics/ prosthetics	2	0
Osteopathy	6	0
Paramedicine	1	1.6
Pharmacy	3	6.5
Physiotherapy	28	24.2
Podiatry	10	3.2
Psychology	29	21.0
Rehabilitation counselling	1	0
Social work	12	9.7
Speech pathology	22	14.5

Student Administrative Tasks

The most common student administrative duties for the student clinics were writing progress notes, writing and sending letters to other health professionals, uploading client documentation into medical record systems and scheduling clients for appointments (Table 6). One clinical supervisor reported that students sometimes performed reception duties, and another reported that students were involved in collecting client surveys.

Table 6

Administrative Tasks Completed by Students in Student Clinics

Task	Number of respondents (n=65)
Answering the clinic phone	13
Scheduling clients	27
Allocating clients to students	11
Listing clinic consumables or equipment for purchase	10
Ordering clinic consumables or equipment	1
Writing progress notes	62
Writing letters to health professionals	57
Sending letters to health professionals	34
Uploading client documentation into a medical record system	46

Clinical Supervisory Models Employed in Student Clinics

Almost half of the clinical supervisors delivered health services to clients in the student clinic and had their own client caseloads. The number of clinical supervisors employed in each university student clinic varied widely (mean 6, range 1-50). Thirty-five supervisors did not deliver interprofessional supervision, whereas 26 did and four were not sure. Of those 26, 18 reported that formal education or training in interprofessional supervision was not a requirement of their role before supervising the health students.

The supervisors shared several challenges with health student clinics (Table 4), one of them being difficulty in achieving true interprofessional collaboration despite intentions to do so. There was significant variability in how clinics were structured, with some operating as multidisciplinary rather than interprofessional, and others offering only ad hoc or partial interprofessional experiences. Differences in clinic models, supervision structures, and service delivery approaches may further contribute to inconsistencies in student learning experiences across settings.

Co-Design in Student Clinics

Twenty-three supervisors out of 65 indicated co-design practices were employed during clinic set up or as service improvement activities. Co-design is where multiple stakeholders contribute solutions towards a product or service due to their expert position as service users or providers (Karlsen et al., 2024; Sanders & Stappers, 2008). Internal stakeholders were most prevalent in clinic co-design, such as supervisors themselves (n=23), academic team (n=21), clinic managers (n=16), and students (n=14). Clients (n=6), family members (n=2), and support workers (n=2) were also less involved (Table 2).

Discussion

This study surveyed health sciences deans and clinical supervisors to examine the distribution and characteristics of interprofessional and multidisciplinary health student clinics in Australian and New Zealand universities. Findings from 34 universities indicated wide variability in operational models. Multidisciplinary models were more widely used at student clinical placement sites, despite growing efforts by clinical supervisors to implement interprofessional education. Most student clinics were in metropolitan areas, where supervised health professional students commonly delivered assessment and treatment services to adults and older adults with musculoskeletal disorders and chronic diseases.

Interprofessional clinical education is an evolving area of interest in universities across the world (Jensen et al., 2023; Shuyi et al., 2024; Timm & Schnepper, 2021; Törnqvist et al., 2023). A growing body of literature supports the benefits of interprofessional student clinics (Hopkins et al., 2022; Shrader et al., 2023; Webster et al., 2024) and their role in contributing to a sustainable workforce (Nagelkerk et al., 2021). Surveyed universities in Australia and New Zealand showed growing recognition of the value of interprofessional and multidisciplinary health professional student clinics for preparing graduates for their future roles in the care economy and health workforce (Martin et al., 2023; Naumann et al., 2021; Yap et al., 2024). While various models of health student education exist (Grace, 2021; Shrader et al., 2023; Wynne & Cooper, 2021), we found that multidisciplinary student clinics are currently most often used for health professional education in Australia and New Zealand, which reflects healthcare practice in real life (Saint-Pierre et al., 2018; Martin et al., 2021). These clinics offered students hands-on experience in teamwork, communication, and client-centred care. They tended to rely on incidental opportunities for student collaboration across disciplines rather than planned interactions (Walker, 2023). Although our focus was not on single discipline clinics, these were included in this work, aligning with Green and Johnson (2015) and Tong et al. (2022), who noted that discipline-specific skills can also serve as a foundation for teamwork and the development of a professional identity.

As with the UK (Power, 2019), Ireland (Kavannagh et al., 2015), Canada (Ng & Hu, 2017), Europe (Drexler et al., 2020), Africa (Müller et al., 2024), US (Farlow et al., 2015) and Brazil (Rodrigues da Silva Noll Gonçalves et al., 2023), many of the universities that we surveyed had multidisciplinary and single discipline student clinics as a core part of their clinical education models. Only a proportion implemented interprofessional student clinics. The lower number of interprofessional student clinics may be associated with challenges in implementation, such as the complexity of coordinating student and staff timetables across multiple disciplines (Collis et al., 2024; Forbes et al., 2021; Kent et al., 2018). Other constraints include securing sustainable funding, which has also been seen in student clinics worldwide (Broman et al., 2023; White et al., 2018), particularly in those serving disadvantaged and rural populations (Ng & Hu, 2017). Ensuring ongoing faculty support for cross-discipline student supervision and student clinic implementation is key (Baer et al., 2016). As noted by Frie et al. (2021), academic-community clinical education partnerships developed by faculty leaders are also necessary for ensuring a sustainable collaborative service.

The current study identified both barriers and facilitators to implementing student clinics as part of health student clinical education. In line with global evidence, timetabling issues (Collis et al., 2024; Kent et al., 2018; Prestes Vargas et al., 2025), insufficient staff and resources (Copley et

al., 2007; Fröberg et al., 2018; Lash et al., 2014), and low access to clinic facilities (George et al., 2017) were barriers to delivering both interprofessional and multidisciplinary health student clinics in Australia and New Zealand. In agreement with previous literature (Roberts et al., 2024; West et al., 2016), we found that facilitators to interprofessional practice included student timetable alignment across disciplines, joint clinic delivery with university-industry partners (Collis et al., 2024), availability of temporary clinics (Bird et al., 2022; Sargison et al., 2021), physical proximity of single discipline clinics (Martin et al., 2021), and shared pedagogy and governance models (Fjaagesund et al., 2024). Structured team meetings (Nisbet et al., 2015), delivery of student orientation to tasks on day one (Farlow et al., 2015) and the use of flexible supervision and service delivery models were also identified as facilitators to the delivery of interprofessional student clinics in this study and previous literature (Collis et al., 2024; Müller et al., 2024). These findings highlight the importance of strategic planning and institutional collaboration to support sustainable interprofessional student clinic models in health education.

Co-design practices in health student clinics were reported by just over a third of our respondents. Co-design can be associated with improved student teamwork and interpersonal skills in health student clinics (Wilson et al., 2024). It has also been linked to enhanced service efficiency (Pirinen, 2016), better patient outcomes (Bird et al., 2021), and cost benefits in healthcare (Silvola et al., 2023). Co-design has been argued by some (Collis et al., 2024; Pirinen, 2016) to support sustainable clinic models by fostering collaboration between students, faculty, and external organisations that host students for clinical placements. The inclusion of internal and external stakeholders in student clinic co-design may help shed light on the solutions to overcome some of the identified barriers to the delivery of interprofessional student clinics. Consultation with a range of stakeholders may also contribute to the implementation and sustainability of interprofessional student clinics within universities (Collis et al., 2024) and external organisations (Pirinen, 2016).

Practical Implications

From a practical standpoint, these findings offer directions for universities seeking to strengthen the student learning experience during clinical placement. Given that timetabling and resourcing constraints remain a consistently identified barrier to the implementation of interprofessional clinical education, institutions may prioritise cross-faculty coordination of student schedules early during clinical placement planning. Relying on incidental overlap between disciplines allows some exposure to interprofessional practice, however intentionally embedding structured team meetings and joint clinical tasks into student schedules, for example, may facilitate translation of evidence into practice.

The relatively low uptake of co-design practices identified in this study also points to a potential area to enhance clinic sustainability. Involving internal and external placement stakeholders in clinic design may help to identify solutions to barriers such as funding, staffing, and non-aligned student schedules. For universities weighing whether to pursue multidisciplinary or interprofessional clinic settings, our findings suggest that multidisciplinary models may act as stepping stones towards interprofessional models. The complexities of implementing true interprofessional student clinics still appear to require a targeted, strategic approach from the ground up. However, the more readily available multidisciplinary models may foster

interprofessional initiatives alongside their programs, allowing for institutional adaptation as capacity grows.

Theoretical Implications

Much of the literature treats interprofessional and multidisciplinary student clinics as distinct models. Our findings suggest that in practice these student clinic models are not as distinct, with the term 'interprofessional' being used to describe clinics that are truly multidisciplinary but include some collaborative activities. This is consistent with literature describing blurred boundaries between operational models of healthcare (interprofessional, multidisciplinary, cross-disciplinary, transdisciplinary) (Martin et al., 2022) and of student placement (student-led clinics, traditional hospital placement, service-learning) (Nagel et al., 2022). These distinctions appear to be shaped by organisational structures, leadership style and intent. Clinical supervisor views suggest that leadership and intent may matter more than the clinic's operational label in determining the integration of practice and education. Future research could therefore characterise clinics descriptively by their degree of integration during what appears to be a transition period between siloed and collaborative healthcare education.

Limitations and Future Research

Our study had some limitations. Not all Australian and New Zealand universities responded, possibly related to challenges in obtaining staff engagement with online surveys (Ye, 2007) and requiring staff to quickly respond to emails (Daikeler et al., 2020). Nevertheless, the response rate was similar to other studies in Europe (Huwendiek et al., 2010) and the United States (Brown et al., 2010). Another limitation was that our survey did not include data from students or patients with lived experience of interprofessional clinics, which could contribute insightful knowledge towards student clinic impact and feasibility. Details of the financial models and infrastructure used for university clinics were beyond the scope of our survey and these can be barriers to long-term viability (Haines et al., 2014; Khalili et al., 2022).

Future research could incorporate the perspectives of varied stakeholders to better understand the facilitators and barriers to running interprofessional student clinics. While clinical supervisors can offer insight into the on-the-ground experience of facilitating interprofessional clinical learning while safeguarding care quality, clinic directors can shed light on operational challenges and costs. Students, as consumers of contemporary education, can act as catalysts for change if their voices are consistently included in clinic design. Finally, as patient-centred care is a pillar of interprofessional education and practice, patient perspectives could be considered integral in clinic planning and sustainability.

Conclusion

Student clinics are frequently used for health student clinical education, yet there are variations in where and how they are implemented across Australia and New Zealand. Although interprofessional student clinics are gaining global interest, multidisciplinary student clinic models currently appear to have the most traction in Australia and New Zealand. While there are key challenges in implementation, many clinical supervisors voiced a commitment to delivering interprofessional clinical education and highlighted the need for better integration, coordination, and resourcing.

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