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Policy and preference: the intersection of attendance hurdles and student perceptions of practical classes

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Abstract

Background Practical classes and skills labs, where students learn, practice, and demonstrate key professional and technical skills, are essential in health professional education. As such, attendance at practical classes has historically been mandated and, in some cases, an "attendance hurdle" (i.e., mandatory minimum attendance requirement that students must meet to pass the course) is applied to subjects where practical classes are a core part of the curriculum. We aimed to explore students' attitudes, beliefs and experiences of attendance hurdles for practical classes.

Methods We surveyed students from entry-to-practice programs in Medicine, Dentistry, Oral Health, Optometry, Physiotherapy, Social Work, Nursing, and Speech Pathology who were currently or previously enrolled in a subject/s with attendance hurdles for practical classes. In a single online survey, students answered multiple-choice, ranking, and Likert questions about their attitudes, beliefs, and experiences of attendance hurdles for practical classes. Data were analysed descriptively and with Pearson chi-squared test of association.

Results Sixty-three percent (n=362) of 575 students who completed the survey wanted to maintain attendance hurdles. In contrast, almost 80% of students stated they would attend 80% or more of classes without attendance hurdles. Many students believed that attendance hurdles could adversely affect some individuals (e.g., due to personal circumstances and sociodemographics), and half believed as adult learners, they should decide whether to attend practical classes. Students valued the in-class tutor feedback and application to clinical practice that practical classes offered. Students suggested that greater flexibility in the timing of practical classes would be more likely than hurdles to improve attendance.

Conclusions The advantages of participating in practical classes to develop essential clinical skills are evident to students, and likely motivate them to attend most scheduled classes. Numerous factors can lead to student absences, and mandating attendance may disadvantage some students. Alternatives to attendance policies could include offering scheduling flexibility and student sign-up, accommodating students' personal and health needs, and aligning classes to student values.

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Introduction

On-campus practical classes are a mainstay educational approach across health professional education. Educators typically use these classes to teach critical technical (e.g., clinical skills) and non-technical skills (e.g., professional behaviours and communication) [1, 2]. Because these skills are core competencies for safe practice, educators often mandate attendance at practical classes [3]. Attendance hurdles in university courses are shaped by a range of factors, including institutional policy and/or accreditation requirements that influence individual course director's decision-making regarding student attendance. However, there is also a tradition of attendance hurdles based on the assumptions that students are more likely to attend practical classes when attendance is mandatory, and that increased attendance may, in turn, enhance the acquisition of essential skills and competencies is another factor [4].

When a student is unable to attend class, for example, due to illness, they are required to apply for special consideration, supported by evidence, such as a health professional report. The process is costly to the student and may place an unnecessary burden on health services. Equally, administering attendance records, processing special considerations, delivering make-up classes, and setting and assessing additional work where hurdle attendance has not been met can significantly burden academic and professional staff. In cases, where students are unable to meet attendance requirements despite these processes, a fail grade for the subject may be recorded, an outcome that can have significant academic, financial and emotional consequences. However, some educators argue that if students demonstrate they have mastered the designated skills then the number of classes attended should not dictate whether they pass or fail the subject [5].

For these reasons, it is important to consider whether mandating attendance is evidence-based. We are unaware of any studies investigating attendance hurdles in health professions education. Numerous studies have investigated whether practical class attendance improves academic performance in health professions education [6–9]. While these studies show that practical class attendance is generally associated with academic performance, the size of these associations varies considerably, and the meaningfulness of these relationships is unclear [6–9].

In addition to a lack of evidence showing benefits, attendance hurdles may also disadvantage some students, for instance, those with work, carer and family responsibilities or health issues that impact attendance [10]. Indeed, health issues, work responsibilities, and social factors are key barriers to tertiary participation and performance [10–12]. Mandating attendance is also potentially a paternalistic approach to educating adult students—a practice based on "doing things the ways they have always been done" [5]—and risks infantilising students and negatively impacting their motivation to learn [4].

Without sufficient evidence to determine whether practical class attendance or associated policies positively impact student academic or clinical performance, it is important to understand students' perspectives on mandating practical class attendance. To our knowledge, no studies have investigated what health professions students think about practical class attendance and related policies. Therefore, we aimed to understand the experiences, attitudes, and beliefs about attendance hurdles for practical classes among medical, dental, and allied health students.

Methods

This study was reviewed and approved by the University of Melbourne Ethics (ID 26457).

Study design

A cross-sectional online survey of entry-to-practice health professional, undergraduate and postgraduate students. This study was reported according to Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines (see Appendix 1) [13]. It was approved by the University of Melbourne ethics committee (ID = 26457). This study adhered to the Declaration of Helsinki.

Setting

Current students from entry-to-practice programs in the following programs were invited to participate: 1) Doctor of Medicine, Dental Surgery, Physiotherapy and Optometry and Master of Social Work, Nursing Science, Speech Pathology, and Bachelor of Oral Health at the University of Melbourne. Students from these courses were eligible to participate if they had/were enrolled in a subject/s with hurdle attendance for practical classes. Subjects with attendance hurdles were identified in consultation with the discipline course director or Director of Teaching and Learning. Thirty-seven subjects were identified as having attendance hurdles for practical classes across these courses as follows: Medicine [4], Dentistry [11], Physiotherapy [6], Optometry [4], Social Work [1], Nursing Science [5], Speech Pathology [3] and Oral Health [3]. Subjects identified included teaching technical and non-technical skills delivered in an in-person practical class setting and all subjects had an attendance hurdle. Of the 37 subjects included in this study, 28 subjects including Medicine [4], Dentistry [11], Optometry [4], Nursing [3], Speech Pathology [3], Social Work [1] and Oral Health [2] required 100% attendance at practical classes. Two Physiotherapy subjects required > 95% attendance,

three required > 85%, one required 85%, two Nursing Science subjects required 80%, and one Oral Health subject required 75% attendance.

Participant recruitment

Information about and an invitation to participate in the study was advertised in each course-specific student community on the Learning Management System (LMS). The announcement was made in semester two to capture the maximum number of students, as all students would have completed or started a subject with an attendance hurdle at that point. This study adhered to the Helsinki Declaration. An independent research assistant (MM), not involved in teaching, assessing, or administering any subjects or courses, posted the study advertisements and was the contact for any student/participant questions. The advertisement included a plain language statement (PLS) and an electronic link to an anonymous online survey. The PLS outlined the students right to right to refuse to participate in the research. On entering the survey students were again provided with the PLS and they were assured of confidentiality, anonymity, and data security. Students who did not want to proceed were asked to exit the survey. Students who wished to proceed were asked to confirm they had received and understood the PLS and were asked to check a box to indicate their consent, complete and submit the survey. Participants could withdraw at any point during the survey.

A financial incentive of $50 electronic gift vouchers to the first five and $30 to the subsequent 30 students was offered to those who completed and submitted the survey and opted in to be eligible. Students who opted in to be eligible to receive the gift vouchers were provided with a separate link at the bottom of the survey to a second and separate survey where they could provide contact details that were not linked to their survey responses and managed by the independent research assistant (MM).

Data collection

The survey was designed by the research team, which comprised academics from Medicine, Dentistry, Physiotherapy, Optometry, Social Work, Nursing Science, Speech Pathology, and Audiology who teach and/or coordinate subjects with and without attendance hurdles for practical classes and a research assistant (TH). Once developed, the survey was piloted with a group of final-year students drawn from the faculty. No changes were made to the survey as a result of the pilot. The survey (see Appendix 2) was accessed online using the Qualtrics (Provo, UT) platform. All data was collected in a single online survey between September 13th and October 29th, 2023. Participants were asked about what courses they had previously undertaken or were undertaking with attendance hurdles, their age, and whether they were domestic or international students. They then answered multiple-choice, ranking, and Likert questions about attitudes, beliefs, and experiences of attendance hurdles in health professions education.

Data analyses

Descriptive analysis was used to summarise student age, course, and international versus domestic status, as well as questions with Likert scales.

Pearson chi-squared test of association was carried out to determine the relationship between those students who had replied yes, no, or unsure to the question of maintaining attendance hurdles with other variables, including age, course, and international vs. domestic status. This tests the null hypothesis of no association between the response to mandating attendance and each of the demographic features in reporting the $\chi 2$ statistic, degrees of freedom (df), and P-values.

Results

Eight hundred and thirty-four students participated in the study. However, 259 (31%) of participants did not answer questions beyond the initial demographic questions (data was not imputed for these participants with missing data). Thus, a total of 575 students completed the survey, representing approximately 18.5% of the ~3100 students across all relevant disciplines and year levels who were invited to participate.

Characteristics of those who completed the survey and did not complete the survey were broadly similar (See Appendix 3 for a description of the participants not completing the survey for whom only demographic data was available). The remaining 575 students completed the survey in full and are presented in the results.

Table 1 shows participant demographic data and Table 2 shows responses to two questions: (1) Do you think attendance hurdles should be maintained? and (2) Without attendance hurdles, what percentage of classes would you attend? Findings for the attitudes towards practical class attendance and attendance hurdles, and reasons for missing practical classes are described below and depicted in Tables 3 and 4; Figs. 1 and 2.

Attitudes towards practical class attendance and attendance hurdles

62% of students ($n = 357$) responded "yes" to the question "Do you think attendance hurdles should be maintained?" Cross-tabulation of the yes responders with demographic characteristics revealed no significant association to age ($\chi 2 = 4.44$, df = 4 $P = 0.350$) or to student origin ($\chi 2 = 4.39$, df = 2, $P = 0.112$). However, there was a significant association between responding "yes" to maintaining attendance hurdles and the course the student was enrolled in ($\chi 2$-78.28 df = 14, $P < 0.001$). Doctor of Optometry (89.7%)

Table 1 Participant demographics

Characteristic	Responses *n* = 575*
Course	
Doctor of Medicine	183 (32%)
Doctor of Dental Surgery	105 (18%)
Master of Nursing Science	82 (14%)
Doctor of Physiotherapy	72 (13%)
Bachelor of Oral Health	50 (9%)
Doctor of Optometry	29 (5%)
Master of Speech Pathology	41 (7%)
Master of Social Work	13 (2%)
Background	
International	135 (23.5%)
Domestic	440 (76.5%)
Age in years	
younger than 18	4 (1%)
18–24	343 (60%)
25–30	182 (32%)
30–35	32 (6%)
35–40	10 (2%)
older than 40	4 (1%)

*Percentages may not equal 100 because of rounding

Table 2 Responses to preference to maintain hurdles and likely practical class attendance in the absence of hurdles

Characteristic	Responses *n* = 575*
Maintain attendance hurdles?	
Yes	357 (62%)
No	147 (26%)
Unsure	68 (12%)
Missing	3 (1%)
Likely attendance in the absence of hurdles?	
% of classes	
> 95%	210 (37%)
80–94%	245 (43%)
65–79%	86 (15%)
64 – 50%	15 (3%)
< 50%	19 (3%)

*Percentages may not equal 100 because of rounding

and Master of Nursing (80.5%) students were most likely to respond "yes" to maintaining attendance hurdles. A preference to maintain hurdles among Medical (65.8%), Dental surgery (65.4%), and Physiotherapy (61.1%) students was similar followed by Social Work (53.9%) while Bachelor of Oral Health (38%) and Master of Speech Pathology (19. 5%) students were least likely to support attendance hurdles.

Of the 575 students reporting how many classes they would attend without attendance hurdles, 79% ($n = 455$) indicated they would attend 80% or more classes, while 3% ($n = 19$) indicated they would attend fewer than 50% of practical classes.

Table 3 Reasons why attendance hurdles or mandatory attendance should be removed for practical classes/simulations/skills laboratories ($n = 575$)

Reason	Strongly Agree/ Agree *n*= (%) *	Neutral *n*= (%) *	Disagree/ Strongly Disagree *n*= (%) *
Special considerations that result from missed class costs money and time	302 (53%)	169 (29%)	104 (18%)
No evidence to support attendance hurdles	195 (34%)	201 (35%)	197 (31%)
No evidence that attendance improves skills acquisition	154 (27%)	121 (21%)	300 (52%)
Adult learners should be able decide when to attend class	325 (57%)	111 (19%)	139 (24%)
May cause students to drop out	219 (38%)	124 (22%)	232 (40%)
May affect recruitment to courses	154 (27%)	158 (28%)	263 (45%)
Reduces student motivation to learn	175 (30%)	128 (22%)	272 (47%)
Students would attend most classes without the hurdle in place	282 (49%)	110 (19%)	183 (32%)
Attendance hurdles may disadvantage some students, including those with carer responsibilities, work demands, or other social or personal factors.	467 (81%)	71 (12%)	37 (6%)

*Percentages may not equal to 100 due to rounding

Table 3 shows student responses to nine statements about why attendance hurdles should be removed for practical classes/simulations/skills laboratories using a 5-point Likert scale (strongly agree, disagree, neutral, disagree, and strongly disagree). More than 50% of students agreed or strongly agreed with removing hurdles for the following reasons: (1) attendance hurdles may disadvantage some students, including those with carer responsibilities, work demands, or other social or personal factors ($n = 467$, 81%); (2) adult learners should be able to decide when to attend class ($n = 325$, 57%); and (3) special considerations that result from missed class costs money and time ($n = 302$, 53%).

Table 4 shows student responses to 14 statements about the benefits of observing and practising technical and non-technical skills in on-campus practical classes using a 5-point Likert scale (strongly agree, disagree, neutral, disagree, and strongly disagree). Over 80% of students agreed or strongly agreed with 10 statements, and over 72% with 12 statements. There was no statement where less than 50% of students agreed or strongly agreed. The three highest rated statements were: (1) I can observe demonstration of skills by a tutor (89%, $n = 496$), (2) I can practice the skills required for clinical practice (89%, $n = 496$), (3) I can practice technical skills using equipment (88%, $n = 491$).

Table 4 Statements about the benefits related to observation and practice of technical and non-technical skills in on-campus practical classes (*n* = 552*)

Statement	Agree/ strongly agree *n*= (%)	Neutral *n*= (%)	Disagree/ Strongly disagree *n*= (%)
I can observe demonstration of skills by a tutor	496 (89.86%)	24 (4.35%)	32 (5.80%)
I can observe demonstration of skills by a student peer	410 (74.28%)	90 (16.30%)	52 (9.43%)
I can practice technical skills on a model/equipment	473(85.69%)	42 (7.61%)	37 (6.71%)
I can practice technical and non-technical skills on a student peer	457(82.79%)	52 (9.42%)	43(7.79%)
I can practice communication skills on peers	456 (82.61%)	58 (10.51%)	38(6.88%)
I can practice technical skills using equipment on my peers	451 (81.70%)	51 (9.24%)	50 (9.06%)
I can practice technical skills using equipment	491 (88.94%)	41 (7.43%)	20 (3.62%)
I can practice OHS	355 (64.32%)	140 (25.36%)	57 (10.33%)
I can practice the skills required for clinical practice	496 (89.85%)	35 (6.34%)	21(3.80%)
I can prepare for assessment of clinical skills e.g. OSCEs	472(85.51%)	54 (9.78%)	26 (4.71%)
I can ensure I have met the subject intended learning outcome/s for the subject	410 (74.27%)	99 (17.93%)	43 (7.79%)
I can practice behaviours expected in clinical practice	448 (81.16%)	67 (12.14%)	37 (6.71%)
I can practice technical and non-technical skills on a tutor	345 (62.50%)	101(18.30%)	106 (19.20%)
I can develop safety in my clinical practices prior to practicing on the public	473 (85.69%)	54 (9.78%)	25 (4.53%)

OHS: Occupational health and safety

Reasons for missing practical classes

Figure 1 shows the reasons students identified for missing practical classes and the percentage of times they were ranked into the following categories: definitely, sometimes, not a reason and unsure. The reasons are grouped into one of 4 themes: (1) Health (acute illness, chronic illness, I was stressed, I needed mental health day); (2) Responsibilities (carer, family issues, lack of childcare and need to work; 3) Logistics (time of class, day of class and transport); and 4) Engagement (class is boring, don't feel confident to demonstrate, don't feel confident to practice, and don't like peers). In the health theme, acute illness was ranked most often as the reason that 'definitely' causes students to miss practical classes (63%) and was the highest ranked 'definitely' reason overall. In the responsibilities theme, the need to work was ranked as 'definitely' for 45% of responses and the second highest ranking overall. The highest scoring 'definitely' reasons in the logistics theme were a time of class (36%) and transport (35%), which were the third and fourth highest scoring 'definitely' reasons overall, respectively. There were no reasons within the engagement theme that were identified reasons students missed class. Instead, reasons in the engagement theme reached the highest ranking in the 'not' a reason. Specifically, 63% and 62% of participants ranked "don't feel confident to demonstrate" or "don't feel confident to practice" as 'not' a reason for missing class, respectively. The only 'not' a reason that scored higher was a "lack of childcare" from the responsibilities theme (67%).

Encouraging practical class attendance

Figure 2 shows student rankings for the usefulness of strategies (very, maybe, unsure, and not useful) proposed to encourage students to attend practical classes if attendance hurdles were removed. The three strategies most often ranked by students as "very helpful" were: (1) Flexible timing of practical classes (79%), (2) Value and application to practice (69%), and (3) Examination of technical skills (65%). Only one strategy was indicated as "not" useful by more than 20% of participants, which was "Marks for attendance" (32%).

Discussion

Beliefs about attendance hurdles

Our findings highlight an important tension: while 62% of students responded "yes" when asked if they felt attendance hurdles should be maintained, almost 80% of students stated that without attendance hurdles, they would attend 80% or more of classes. These student attitudes suggest that hurdle attendance is potentially not required unless educators are aiming for greater than 80% practical class attendance. We also found that many students recognised important reasons to remove hurdles. Namely, about 8 in 10 students believed that attendance hurdles could disproportionately affect some individuals (e.g. due to health and financial reasons), which was consistent with the top reasons students reported for missing practical classes (i.e., acute illness and the need to work). Lastly, more than half of students believed they should be able to decide, as adult learners, about attending practical classes.

Our findings thus highlight a potential conflict between students wanting attendance hurdles but also recognising issues with them and believing they would attend most classes without them. So why do some students want attendance hurdles, despite recognising their limitations? We tentatively suggest that students may prefer to abdicate decision-making regarding attendance in preference

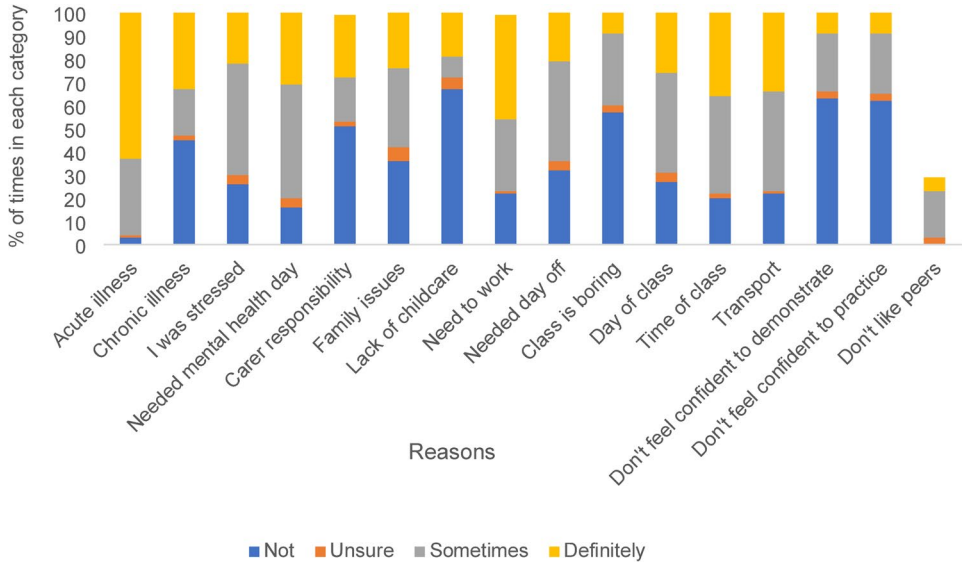

Fig. 1 Ranking of statements about the reason/s (if any) that affect a student's ability to attend practical classes

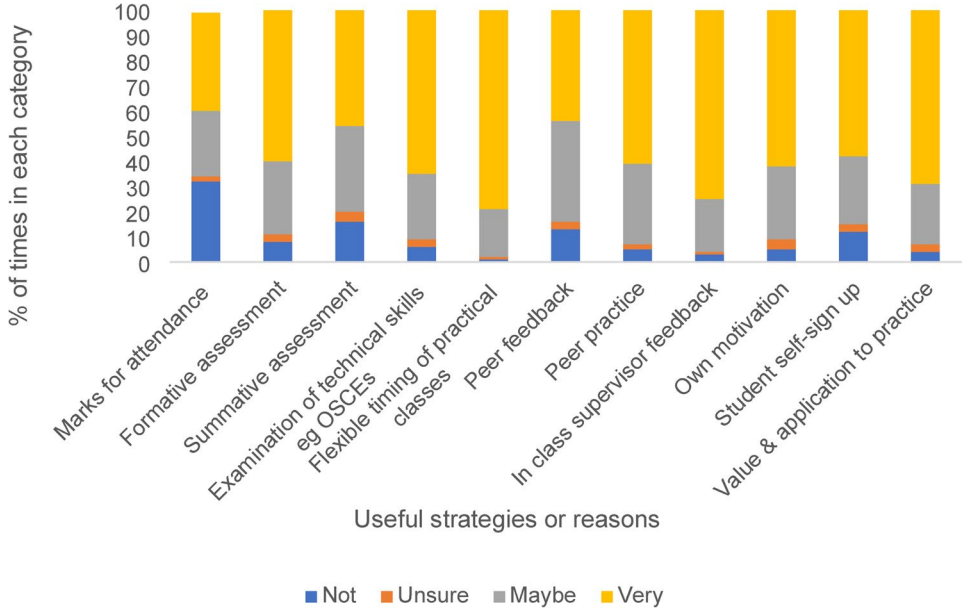

Fig. 2 Ranking of strategies or reasons, that would be useful to encourage you to attend on-campus practical classes/simulations/skills laboratories if attendance hurdles were to be removed

for mandatory/hurdle attendance. However, we did not find research within tertiary education to support this hypothesis. Broader research shows that in some circumstances, people may prefer to place the responsibility of decision-making onto others (e.g. when a decision is difficult and may lead to anticipated regret) [14]. These findings require future investigation in health professions students.

Our findings provide important insights into why students may miss practical classes. Acute and chronic illness were the leading reasons why people missed classes, with about 1 in 3 participants missing classes because of chronic illnesses. Indeed, chronic illness is common among university students, particularly anxiety and depression [15, 16]. These students also often report unmet health needs in tertiary education, such as a lack of structural and educational support for their conditions and associated disabilities [17]. This barrier to learning converged with a key reason why students would remove attendance hurdles difficulties with managing other life stressors (e.g. managing time and money). Taken together, mandatory attendance may increase barriers to participation and academic disadvantage, particularly among certain groups of students (e.g., those with

chronic illness and worker responsibilities) engaging in entry-to-practice health professions education.

Benefits of practical classes and encouraging participation in them

Students recognised numerous benefits of attending on-campus practical classes. Notably, students valued observing and practising clinical and technical skills students required for their intended health profession. They particularly viewed working with tutors as an important aspect of attending practical classes for learning these skills. These findings are consistent with past research. Students often attend tertiary education classes because they want to learn from the expertise of academic staff and their peers to develop a comprehensive understanding of the course content [18, 19]. Our findings build on this research, showing that students explicitly value the opportunities and support to develop their clinical skills as a reason for attending on-campus practical classes. Aligning teaching with clinical skills was also a key strategy students believed could drive in-person, practical class attendance. Other key strategies were flexible timing, student self-sign-up, and assessment. Previous literature identifies numerous strategies for enhancing attendance among university students, including students in health professions education, which broadly align with our findings. These strategies range from administrative changes (i.e. timing of classes, workload, and assessments), perceived quality of teaching (e.g. organisation of the teacher and their content), and format of teaching (e.g. more likely to attend small group learning than lectures) [10, 20, 21]. Our findings contribute to this research space by informing recommendations specifically for encouraging students to attend practical classes in health professions education, which we highlight in the following section.

Implications for practice

The majority of the entry-to-practice health profession students participating in this study expressed a preference for attendance hurdles for on-campus practical classes. They also recognise these policies could disproportionately impact some students, particularly those with health problems and responsibilities outside of the university, such as caring and working. Importantly, tertiary educators for health professions may need to carefully consider if choosing to mandate practical class attendance may disproportionately impact students already most disadvantaged in our tertiary academic systems.

Our findings provide preliminary evidence that could inform other approaches to encouraging practical class participation. These strategies include aligning class learning outcomes and content with student values, as well as seeking to remove barriers to participation for some students. Educators could aim to implement flexible, practical class attendance timetabling, which allows – as much as plausible – student autonomy in selecting or changing class times to accommodate personal and health needs. Hybrid online and in-person teaching styles may also support some students during periods where on-campus practical class attendance is difficult (e.g. illness flares). Lastly, academic teaching staff may want to ensure that practical classes deliver value to students. Most students want these classes to reflect the clinical demands of their intended health professions, and they want tutors to support them in developing these skills in person. For in-person classes, educators could use approaches that centre on these learning outcomes and seek to enhance students' learning experiences (e.g., small group problem- or case-based learning) [4, 22, 23]. For theory, educators could explore other online or hybrid avenues for delivering content. Indeed, since COVID-19, an explosion of innovative teaching models has arisen, showing that students are often just as satisfied and learn just as well with newer hybrid teaching models than traditional in-person teaching formats [24–26].

Strengths and limitations

This survey was conducted across seven different health disciplines in a large tertiary institution, drawing on national and international student participants. The survey was collaboratively designed with input from researchers who teach and coordinate courses for numerous health professions; it was also tested among students in an entry-to-practice health profession course. Lastly, we rigorously ensured student participant anonymity would be protected, to limit any potential responder bias present in our data. Limitations of this study include that the study sample is from one university. However, both the literature (Best & Best, 2009) [5] and insights from the authors' national and international professional networks suggest that attendance hurdles are implemented at other universities. A proportion of students who started but did not complete the survey were eliminated from the final analyses. It is suspected that these students may have been motivated by the potential for financial reward to start but not complete the survey. The financial incentive offered to participate may also have meant that students experiencing the most financial duress were more Likely to participate. However, as the incentive was Limited to the first 35 participants and responses were received across the full six-week recruitment period, it is likely those primarily motivated by the incentive responded early, with subsequent responses reflecting broader student participation.

The overall response rate (18.5%) may appear modest however, because the invitation to participate was

distributed broadly as an announcement in the LMS, including to students who may not yet have undertaken the mandatory subject relevant to the study, the response rate is an estimate only. All disciplines were represented in the participant group of 575 students, and their relative proportions broadly reflected the size of each discipline cohort and provided strong coverage of the target population. Moreover, as the study aimed to examine associations between variables rather than make inferences about the overall population, representativeness is less critical in interpreting the findings.

Future research could replicate this study among other national and international tertiary health education settings. Follow-up qualitative research could facilitate a richer understanding of students' attitudes towards attendance hurdles and on-campus practical attendance, such as exploring the tension between adult learner autonomy and the desire to maintain attendance hurdles.

Conclusion

The advantages of participating in practical classes to develop essential clinical skills are evident to students, and these likely motivate them to attend most scheduled classes. However, numerous factors can lead to student absences, and attendance hurdles may disadvantage some students. Universities who employ attendance hurdles could consider alternatives to mandatory attendance policies, such as offering scheduling flexibility and student sign-up, accommodating students' personal and health needs, and aligning classes to student values.

Abbreviations

LMS Learning management system
PLS Plain language statement

Acknowledgements

At the time this study was conducted, the primary author was employed at the University of Melbourne as the Course Coordinator of the Doctor of Physiotherapy program.

Authors' contributions

All authors (K.D., T.H., A.C., S.B., L.C., J.S., S.F., N.H., E.K., J.L., M.M., L.S., B.T.) contributed to the study conception and design. Material preparation, data collection and analysis were performed by M.M. and T.H. The first draft of the manuscript was written by K.D. and T.H. and all authors (K.D., T.H., A.C., S.B., L.C., J.S., S.F., N.H., E.K., J.L., M.M., L.S., B.T.) commented on previous versions of the manuscript. All authors (K.D., T.H., A.C., S.B., L.C., J.S., S.F., N.H., E.K., J.L., M.M., L.S., B.T.) read and approved the final manuscript.

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Data availability

Data is available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

This study was reviewed and approved by the University of Melbourne Ethics (ID.Written information was provided to all students before the study in a plain language statement (PLS), and they were assured of confidentiality, anonymity, and data security. Students were asked to confirm they had received and understood the PLS at the commencement of the study. Completion and submission of the study implied consent. None of the researchers were involved in data collection. This study adhered to the Declaration of Helsinki.

Consent for publication

Completion and submission of the study implied consent for publication.

Competing interests

The authors declare no competing interests.

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