Purpose: Some physician assistant (PA) program directors believe paying clinicians and administrators for clinical sites is fair and necessary, while others regard such practices as undermining traditional altruistic motivations for precepting. The purpose of this study was to assess PA program directors’ attitudes on this topic and describe current practices and future plans regarding compensation to clinical sites.

Methods: A cross-sectional descriptive survey was sent to directors of PA programs with continuing and provisional accreditation status in 2012. Results: Seventy-eight (48%) of the 163 program directors surveyed participated in the study. Although most respondents indicated that paying for clinical sites was not an acceptable practice, almost half believed it would be acceptable if there were standards and definitions for equitable and fair payments. Despite the finding that most respondents’ programs do not pay for clinical sites, nearly half anticipate their programs will be paying for clinical sites in three years, and the cost of such payments will be passed on to students in the form of increased tuition or separate fees. Many indicated a concern that paying for clinical sites may result in monopolies and bidding wars.

Conclusion: While paying clinical sites may be effective for recruitment and retention of clinical sites, most program directors are concerned about the expanded role economics will have for their program. Agreed-upon standards and definitions for fair and equitable payment practices may alleviate some of these concerns. However, the potential effects on students and programs identified in this study necessitate additional research to fully assess what implications this may have on PA education and the profession.


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INTRODUCTION

According to the most recent annual survey of physician assistant (PA) programs in the United States for the 2011–2012 academic year, 19.5% of all PA programs reimburse preceptors for training PA students during clinical rotations. Although there was a slight decrease from the previous year, this represents an increase of 8.5% overall since 1998. Despite this general upward trend in payments for clinical rotations, PA educators do not agree that these payments are fair and necessary, while others regard these payments as undermining traditional altruistic motivations for teaching students.

In 2010, Simons asserted that paying preceptors may potentially worsen the current critical shortage of preceptors and clinical sites. Advocates of paying for preceptors and clinical sites often view the practice as part of a successful business model and an effective tool for recruiting preceptors in a competitive market. Critics note that clinical sites are lost and students displaced if they do not pay for sites. While PA educators disagree about paying for clinical sites, they agree that the shortage of clinical sites poses the most significant barrier to the growth of PA education. In 2013, the Physician Assistant Education Association (PAEA) Board of Directors announced that additional clinical sites are needed “to provide for the burgeoning numbers of PA students across the country. Without these opportunities, the development of the profession will be stalled.”

According to Kevin Lohenry, past president of PAEA, “the most significant challenge facing expansion of PA education is clinical training sites.” Glicken and Lane found 49.4% of PA program directors believed limited clinical sites were a “major” or “very significant” barrier to program expand-
There is little existing research on payment for clinical sites as it relates to PA education. In 1998, Wargula surveyed the 81 existing PA programs to determine which ones paid for clinical sites, the amounts paid, and other factors related to such payments. At the time, nine programs (11%) were compensating clinical sites for student rotations. Among those not paying, 50% indicated they felt pressured to do so. The author proposed that paying preceptors would be an effective tool for securing clinical sites in a competitive market.

In 2010, Simons reported that PA program directors were feeling pressured into paying clinicians and administrators for clinical sites. She explored the reasons why PA programs feel pressured to make such payments and highlighted the discordance between preceptors and PA programs. Simons noted that some preceptors commonly request to receive payments as compensation for what they perceive as lost productivity due to precepting students, while program directors typically do not see such payments as an option due to limited funds. Simons also found that PA programs are pressured further when medical schools actively pay for preceptors. The author indicated that programs that pay preceptors attempt to recover these funds by raising tuition.

A 2013 PAEA issue brief provided PA educators with current information about paying clinical sites and preceptors. The issue brief cited the 2013 AAMC/PAEA clerkship survey in which 21.7% of PA program respondents reported paying for clinical sites. These payments ranged from $100 to $450 per week for each student. The authors also highlighted the results of a 2011 PAEA National Commission on Certification for Physician Assistants (NCCPA) survey that found financial compensation is the least important factor PAs consider when deciding whether to precept. This survey revealed that preceptors were more motivated to precept by the availability of Category 1 Continuing Medical Education (CME) credit, supportive supervising physicians, and quality students than by financial compensation.

There are no set definitions for fair and equitable payments for precepting among the various medical education disciplines. Jones and Gold indicated that compensation practices of medical school clinical preceptors vary greatly by departments within the same facilities. This lack of a common framework for paying clinical faculty often leads to conflicts between clinical faculty and medical school program administrators.

Lobbyists for offshore medical schools (OMS) insist that paying for clinical sites is a successful business model that works for them and hospitals, even though some American medical schools feel threatened by their success. Advocates for these schools also propose that, despite concerns that competition for clinical sites may lead to conflict, US medical schools may ultimately find innovative financing strategies used by OMS to be quite useful.

Medical schools that do not pay for clinical sites are in competition with those schools that do. In 2010, medical school educators in New York claimed that they could not place their students at clinical sites because OMS were paying for their clinical experiences. Clinical sites that previously had accepted American medical students were turning them away. These schools cited budgetary limitations as the primary reason why they could not pay clinical sites the average $400-450 per week, per student that OMS paid. Medical school educators claimed that the increases in tuition required to compete for these sites would make their programs less attractive to...
potential applicants.7 One New York hospital system even signed a $10 million, 10-year contract to provide clinical sites for one OMS.7 In response to this move, the American Medical Association (AMA) issued a statement opposing such payment practices. The statement also affirmed the AMA's support for regulations and legislation that would prohibit "extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities" of American medical students in clinical clerkships.20

Of particular concern to medical school educators is how rising tuition rates and educational debt may deter potential applicants and lessen the diversity of their student bodies.21 Graysen et al found that cost was the number one disincentive for underrepresented minority students considering applying to medical school.22 The authors noted that these underrepresented minority students usually come from low-income families and are particularly concerned with accumulating debt.23 Rising tuition and educational debt may also deter students from rural backgrounds, who also tend to come from low-income families, from applying to medical school.23 A study evaluating matriculation rates from 2001 through 2009 indicated that the number of affluent medical school matriculants is rising.22 At the same time, the percentage of minority groups, such as African Americans, enrolled in medical school remained stagnant.21 Raising tuition eventually could have a profound impact on the number of providers caring for underserved populations, since underrepresented minority students and students from rural backgrounds are more likely to practice in these settings after graduation.24

The purpose of this study was to assess PA program directors' attitudes about, and to describe current practices and future plans regarding, financial compensation to preceptors, administrators, and supervising physicians at clinical sites. The results of this study may affect how PA programs operate in the future. Stakeholders may be able to determine the extent to which other PA programs are planning on stepping up budgetary efforts to deal with increasing demands from clinical sites for payments. Program directors, administrators, and clinical coordinators may obtain a better picture of how competitive the market for clinical sites and preceptors will be long-term. Programs may subsequently be able to better compete in these markets and to secure the long-term viability of their programs.

METHODS

Research Design
The study design was a quantitative, cross-sectional, descriptive survey.

Study Participants
The study population consisted of the 163 program directors of PA programs granted continuing or provisional accreditation by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) at the time of survey distribution in 2012. One PA program had been placed on probationary status by the ARC-PA and thus was excluded from the study. The study was exempted from continuing review by the A.T. Still University Institutional Review Board.

Survey Development
The survey instrument was developed based on a comprehensive review of current literature. No existing validated survey instruments were found to thoroughly assess the existing policies, attitudes, and beliefs of the target population. One survey by PAEA evaluated current practices among PA programs for preceptor payments but was limited to one question about the percentage of total program budget allocated to precepting.1

Survey questions were developed and refined by the principal author based on the study's purpose.25 A preliminary version of the survey was distributed to a group of PA educators and practicing PAs attending the A.T. Still University Doctor of Health Science (DHSc) Winter Institute in February 2012, who were considered stakeholders on this topic. Each participant was screened for their familiarity with issues regarding payment for preceptors. Program directors purposely were excluded from the group to avoid bias related to completion of the final survey instrument. Feedback from the participants was used to further refine the instrument.

A pilot test of the survey was distributed to five PA educators who were not program directors to minimize contamination bias. These five PA educators were clinical coordinators, selected because of their high level of familiarity and involvement with topics covered in the survey. Participants in the pilot test provided feedback regarding the ease of use and the clarity of the survey questions, and they ensured that the survey assessed the intended topics.25 Participants also reviewed each question of a sensitive nature to ensure phrasing elicited the least amount of respondent discomfort possible. The results of the pilot were used to establish face validity and further refine the instrument (see List 1).

Content validity was established as the survey was distributed to a panel of experts consisting of an associate professor of research and statistics at Loma Linda University, the PAEA director of data and research, the PAEA director of professional affairs and education, and an assistant professor at the Yale University PA Program. The panel was selected based on their experience as PA educators, their
List 1. Survey Question Groupings
The survey participants were polled for responses to questions grouped into 10 different categories:

1. Characteristics of clinical site payments
2. Source of funding for clinical site payments
3. Pressure from external sources for clinical site payments
4. Fairness and ethics in clinical site payments
5. Disclosure of clinical site payments
6. Alternate forms of compensation to clinical sites
7. Payments to preceptors under certain conditions
8. Positive effects of paying clinical sites
9. Negative effects of paying clinical sites
10. Characteristics of declining to pay clinical sites

Questions related to payment practices and program demographics were also included in the survey along with questions related to content categories.

familiarity with issues related to PA education, and their expertise in medical education research. These individuals provided feedback and guidance related to whether the survey accurately assessed the content domains it was designed to assess.

Data Collection
In June 2012, an email was sent to the program director of each accredited PA program using a mailing list provided by PAEA. This email included an introductory letter with an electronic link to the survey via SurveyMonkey. The survey was available to all participants for 30 calendar days, with one follow-up reminder notification emailed to all participants 15 days after the initial email. The survey was kept anonymous, and the letter of introduction outlined the potential benefits to the profession that this research was likely to offer. Given the sensitive nature of some of the questions in the survey, program directors were instructed to skip those questions with which they were uncomfortable. The goal for the survey was 20% (n = 33) of those invited due to the sensitive nature of the survey and awareness of previous survey response rates through PAEA.

Statistical Analysis
IBM SPSS Statistics (version 20) was used for statistical analysis. Descriptive statistics such as frequencies and percentages were calculated for all study variables. Response categories for the questions about monopolies and bidding wars were combined, with “strongly agree” and “agree” reported as “acceptable to pay,” while “strongly disagree” and “disagree” were reported as “not acceptable to pay.” Neutral responses to these questions were not included in the analysis. Programs in existence for 1–5 years were reported as “new programs,” while the remaining responses were combined and reported as “older programs.”

RESULTS

Description of Sample
Seventy-eight respondents completed the survey for a response rate of 48%. The majority of respondents indicated they were affiliated with universities (64.9%), academic health centers (18.2%), or four-year colleges (11.7%) and that their program had been in existence for 11 years or more (74.1%). A summary of demographic characteristics is included in Table 1.

Descriptive Measurements
The majority of respondents (69.2%) indicated that paying for clinical sites was not an acceptable practice (Table 2). Most program directors (91%) also indicated that clinical sites (ie, preceptors, administrators, or supervising physicians) should train PA students in order to “give back to the profession” without expecting financial compensation.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsoring Institution</td>
<td>University</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>4-year college</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Community college</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Military</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Academic health center</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Other*</td>
<td>1</td>
</tr>
</tbody>
</table>

| Program in Existence**          | 1–5 years      | 13  | 16.9 |
|                                 | 6–10 years     | 3   | 3.9  |
|                                 | 11–20 years    | 36  | 46.8 |
|                                 | 21–30 years    | 4   | 5.2  |
|                                 | 31 or > years  | 21  | 27.3 |

* The sole respondent to this question answered “medical school.”
** One survey respondent did not answer this question.
Most respondents believed sharing information regarding clinical site payment practices with other programs (51.3%) or clinical sites (44.7%) would not have any effect on their programs. Respondents from newer programs (defined as in existence 1-5 years) were slightly less likely (20%) than older programs (25%) to perceive paying clinical sites as an acceptable practice.

Most respondents (80.7%) agreed that PA programs that pay for clinical sites have an unfair advantage over those that do not. Nearly half of those surveyed (47.4%) strongly agreed with this statement. Almost 72% indicated that rewards, gifts, or other nonfinancial compensation for individual preceptors at clinical sites are acceptable as the sole method of payment. While only 16.6% of respondents indicated that paying for clinical sites is an acceptable practice, 38.5% agreed that payment to clinical sites for administrative costs associated with teaching is acceptable. Nearly 36% indicated that paying for clinical sites is necessary in order to compete with other programs that pay. A complete list of results is provided in Table 3.

Just over 42% of all program directors believed that it would be acceptable to pay clinical sites if there were standards and definitions to determine what constitutes equitable and fair payments. They were also more likely to deem this an acceptable practice if payments were made to preceptors who teach students (30.8%) or if clinical sites were in critically underserved areas (35.9%) (Table 4).

Most program directors strongly agreed with the statement that paying clinical sites would result in monopolies (48.7%) and bidding wars (67.5%). These results are outlined in Table 5. Some program directors that agreed or strongly agreed with the statement, “I believe that payment for clinical sites is an acceptable practice,” also responded that doing so might result in PA program monopolies (16.4%) and bidding wars (18.2%).

Nearly two-thirds of all program directors indicated they had lost clinical sites in the last year as a result of not providing payments, with 61% of all respondents indicating that they feel pressured to pay clinical sites. Program directors feel pressured to make such payments by administrators (72.3%), preceptors (72.3%), PAs’ supervising physicians (54.3%), and the belief that other programs in their areas are paying (70.2%).

The majority of the respondents (85.7%) reported that their programs did not pay for clinical sites at the time of the survey. However, as noted in Table 6, almost half of all respondents anticipated that their programs would be paying clinical sites in three years (2015).
When asked for the current source of funding to pay clinical sites for the current year, 40% responded with “an increase in student tuition.” Half marked “institutional support apart from tuition.” The largest percentage of those currently paying clinical sites (40%) indicated they allocated 16–20% of their current year budget towards such payments. For questions evaluating future directions, program directors estimated that, in three years, the source of funds for paying clinical sites will be passed on to students in the form of increased tuition (34.6%) and/or separate fees (23.1%). Those programs that currently pay for clinical rotations indicated that they all pay per student (100%) and/or per rotation (80%). Program directors who currently pay clinical sites responded that preceptors are the most common recipients of such payments (80%). Program directors who anticipate paying in the future indicate that preceptors will continue to be the primary payees (72.2% in one year and 86.1% in three years). Programs that cannot pay for sites were queried for their reasons and asked to select all that apply. More than three-quarters of respondents selected “due to financial constraints,” while one-third selected “due to program or sponsoring institution policy.”

**DISCUSSION**

The findings of this study suggest that the majority of PA program directors oppose compensating clinical sites for clinical rotations. This may be due to the belief that clinical sites should train PA students in order to give back to the profession without expecting financial compensation, as indicated by their survey responses. The American Academy of Physician Assistants (AAPA) has stated it is the responsibility of all PAs to “share knowledge and information with patients, other health professionals, students, and the public.”

Many PAs believe that it is inherent in the profession that its members give back through educating the next generation of PAs, and that the roots of clinical precepting are a natural outflow from the profession itself.

Despite clear opposition to paying for clinical sites, almost half of all program directors surveyed anticipate that they will be paying for clinical sites within three years. This view is held by responding program directors despite concerns that such payments may result in monopolies and bidding wars, as well as an unfair advantage to programs that pay. Program directors may anticipate making such payments due to pressures from administrators, preceptors, and PAs’ supervising physicians. Additional pressures to pay can stem from the belief that other programs in their areas are paying or from having lost clinical sites in the last year as a result of not paying. Regardless of the source of pressure, program directors are feeling increasingly obliged now to pay for clinical sites (61%) than they were in 1998 (50%).

More than one-third of all program directors indicated that paying clinical sites was necessary to maintain an adequate number of sites due to competition from other programs. This finding may indicate support for the position taken by Caribbean medical schools and Wargula. Their position is that paying for clinical sites is simply an effective, successful business model based on competition and market forces that benefits programs and clinical sites. Further support for this stance is demonstrated in our

### Table 4. Percentage of Program Directors that Believe It Is Acceptable to Pay Clinical Sites Under the Following Conditions (N = 78)

<table>
<thead>
<tr>
<th>Condition</th>
<th>(% )</th>
<th>(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In geographical areas where they are in high demand by regional PA programs</td>
<td>20.5</td>
<td>16</td>
</tr>
<tr>
<td>If there were standards and definitions to determine what constitutes equitable and fair payments</td>
<td>42.4</td>
<td>33</td>
</tr>
<tr>
<td>In critically underserved areas</td>
<td>35.9</td>
<td>28</td>
</tr>
<tr>
<td>If preceptors who directly teach students receive most or all of the compensation provided</td>
<td>30.8</td>
<td>24</td>
</tr>
</tbody>
</table>

Note: The total percentage exceeds 100% as respondents were invited to “mark all that apply.”

### Table 5. Percentage of Program Directors that Believe Paying Clinical Sites May Result in PA Program Monopolies and Bidding Wars (N = 78)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monopolies</td>
<td>48.7</td>
<td>39.7</td>
<td>9.0</td>
<td>2.6</td>
<td>0</td>
</tr>
<tr>
<td>Bidding wars</td>
<td>67.5</td>
<td>28.6</td>
<td>3.9</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Table 6. Characteristics of Program Payment Practices – Current and Future

<table>
<thead>
<tr>
<th>Programs paying preceptors</th>
<th>Cur. Year 2012</th>
<th>In 1 Year 2013</th>
<th>In 3 Years 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14.3%</td>
<td>26.0%</td>
<td>47.4%</td>
</tr>
</tbody>
</table>
Attitudes, Practices, and Plans Regarding Financial Compensation to Clinical Sites

finding that more than 25% of all program directors believe paying for clinical sites is an effective tool for recruiting and retaining preceptors. These findings may indicate the beginning of greater acceptance of — or resignation to — the competitive and economic forces that affect the market for clinical sites.

While relatively few program directors view paying for clinical sites as an acceptable practice, some indicated there were conditions that would make these payments more acceptable. Almost half indicated that paying sites would be acceptable if there were standards and definitions to determine what constituted equitable and fair payments. Presently, there are no such standards and definitions, leaving PA programs and clinical sites to negotiate freely among themselves. This finding has the potential to substantially influence clinical site payment practices for PA programs that enter into negotiations with facilities or health care systems that choose to develop such standards and definitions. Payment practices may also be affected on a national level should standards and definitions for such practices be recognized by organizations of the profession, such as PAEA and AAPA.

Program directors responded they would be likely to view payments to clinical sites as acceptable for administrative costs associated with teaching their students as an acceptable practice. Clinical sites can incur administrative costs related to training PA students for a number of reasons, such as conducting orientations, coordinating schedules, and providing documentation. Program directors may consider reimbursements for such costs to be fair or reasonable.

Program directors indicated they may consider payments to clinical sites in underserved areas as more acceptable for a number of possible reasons. They may have limited numbers of clinical sites in underserved areas, hampering their students' exposure to learning experiences with underserved populations. Program directors may also view PA student exposure to clinical sites in underserved areas as desirable in hopes that students will choose to practice in such settings after graduation. It is clear that even program directors that generally oppose paying for clinical sites may be open to making such payments under certain conditions.

The results of this study suggest that most program directors do not believe sharing information regarding their clinical site payment practices with other clinical sites or PA programs in their area would affect their programs' outcomes. This finding may indicate program directors are not overly concerned that sharing such practices will create a "domino effect" resulting in additional sites requesting payments. There currently are no data available on PA programs sharing such information.

The study findings that many program directors anticipate paying clinical sites in three years, and raising tuition and fees to fund such payments, provide a glimpse into what may be the future of PA education. Presently, three-quarters of all programs indicate they are unable to pay clinical sites because of financial constraints. Yet raising PA school tuition, which averages $63,098,1 has the potential to motivate potential applicants to pursue alternate health care careers that they consider to be more affordable. This is especially true for underrepresented minorities, for whom cost is the strongest deterrent to applying to medical school.2 This means that applicants from lower income families, who are more likely to be underrepresented minorities and from rural backgrounds, will not be appropriately represented in PA and medical school student bodies despite their propensity to work with under-served populations after graduation.24 Increasing educational costs for this student population could hinder PAEA's objectives9 to "recruit for diversity" and to expand the number of PAs working in medically underserved areas. It is unclear if PA salaries will increase at a rate that will offset possible tuition increases, despite the fact that the job market for PA’s is expected to expand 30% by 2020.27

There are significant similarities between the issues facing PA programs and those facing medical schools related to the market for clinical sites. Both professions have a long history of sel-dom paying for clinical sites and have generally depended on long-standing relationships with health care institutions to provide clinical training. Both professions have felt vulnerable as those schools and programs that are willing and able to pay clinical sites threaten to disrupt these relationships and displace their students. The initial reaction by both PA programs and medical schools is to consider increasing tuition to fund clinical site payments, which could result in deterring applicants and limiting diversity. PA educators may be well-served by keeping a close eye on further developments in medical education, as it might provide them with a glimpse of what lies ahead, with lessons to be learned.

Study Limitations
The study had a number of limitations. Limited demographic information was collected on program directors and sponsoring institutions, preventing possible analysis of data by region. This was done with the intent of maintaining anonymity to ensure an adequate response rate. Some bias may have been introduced as respondents with strong feelings (positive and negative) may have been more likely to respond to the survey. Another limitation was the use of an unpublished,
nonstandardized survey instrument, although a pilot study was conducted to minimize this limitation. One question invited respondents to “mark all that apply”; however, due to an error during the transition of the survey to the online format, respondents were only allowed to select one of four options.

**Study Strengths**
This study is the first of its kind to examine PA program directors’ attitudes and future payment plans for clinical sites. Even though PAEA collects current payment practice information for clinical sites, we collected additional information about such practices as well as future plans for payments.

The study had a high rate of response from program directors, resulting in a significant degree of validity and helping ensure that the results can be generalized to the target population. External validity of the study findings was enhanced by the high degree of comparability between sample demographic characteristics and those of the target population. The majority of the respondents reported that they were affiliated with universities (64.9%), indicating that the survey population is almost identical (62%) in this respect to the target population of all PA program directors as defined in the 26th Annual Report on Physician Assistant Educational Programs in the United States for the 2009–2010 academic year. The majority of the respondents specified that their programs had been in existence for either “11 to 20 years” (46.8%) or “31 or more years” (27.3%). The characteristics of this demographic are also very similar to those of the target population (47.1% and 31.6%, respectively).

**Future Research**
Future research is needed to further define standards and definitions for what constitutes fair and equitable payments to clinical sites. This topic can be explored by representative bodies for the PA profession (PAEA, AAPA), as well as health care facilities and systems that are responsible for the clinical education of PA students. Additional research should be performed to explore further other sources of pressure to pay for clinical sites from competing stakeholders, such as medical schools and other health care professions. Further research should be conducted regarding the possible effects on PA student body diversity of raising tuition and fees to fund clinical site payments. Research on clinical site payment amounts and practices by region should also be done. Lastly, research should be conducted to determine if there are further conditions under which program directors would view payment for clinical sites as an acceptable or unacceptable practice.

**CONCLUSION**
Regardless of whether or not program directors feel pressured to pay clinical sites or simply believe that such practices are an effective way of competing for limited resources, our findings suggest that most anticipate that paying sites will become common practice in the future. A future in which paying sites is the norm has the potential to change the very culture of PA education. Relationships between PA programs and clinical sites, which form the backbone of clinical education, may become based on economics rather than altruism.

Most program directors appear to be concerned about the expanded role economics will play in the already competitive market for clinical sites. Even some program directors that deem clinical site payments acceptable believe that monopolies and bidding wars may ensue. The pool of applicants to PA programs is likely to become more exclusive and less diverse as financially strapped programs choose to raise student tuition and fees in order to pay for sites. Agreed-upon standards and definitions for fair and equitable payment practices may alleviate some of these concerns and level the playing field among programs. PA program leaders considering clinical site payments should make informed decisions based on high-quality research evidence. Program directors and organizations such as AAPA and PAEA should continue to explore this topic and possible solutions so that programs can expand successfully, ensuring the profession will be able to grow and adapt to the changing American health care system.

**REFERENCES**
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