

Part 1. Payment for Clinical Education Experiences: A Historical Perspective

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Background and Purpose: Payment for clinical education (CE) experiences in health care professions has been discussed for many years. Clinical education sites may consider requesting payment to offset expenses, which might include onboarding costs or perceived or real reduction in productivity. The American Council of Academic Physical Therapy–National Consortium of Clinical Educators Task Force on Payment for Clinical Experience explored the history of CE as it relates to payment, costs, productivity, and incentives through this comprehensive literature review.

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Methods: The literature was exhaustively searched through multiple data bases, compiled, and summarized by the authors.

Results: Clinical education is an essential component of physical therapy education. The proliferation of academic programs combined with reimbursement challenges and increased productivity requirements has increased the burden of CE on health care facilities. Research in health care professions has investigated direct and indirect costs of providing CE experiences. While some research showed decreases in productivity while supervising a student, most research in physical therapy revealed increased productivity along with improved quality of care and enhanced recruitment of employees. Motivators for educating students in the CE environment included intrinsic factors of enjoyment, professional obligation, and intellectual stimulation; extrinsic factors such as continuing education credits, discounted courses, and academic appointments were also found. Research revealed that students bring value and enthusiasm to the CE environment in a variety of ways. Payment for CE experiences, more common in physician assistant, medicine, and nurse practitioner education, did not always improve quality and may be unsustainable as competition for clinical experiences grows and student debt increases.

Discussion and Conclusion: Clinical education involves many stakeholders and the topic of payment is multifaceted. This comprehensive literature review highlighted numerous challenges and benefits for providing CE experiences as it relates to payment. This literature review provides background information regarding payment for CE in health care professions and served as foundational work of the Task Force on Payment for Clinical Experience for determining current perspectives related to payment for CE in physical therapist education.

Key Words: Clinical education, Physical therapy, Payment.

INTRODUCTION

Payment for providing clinical education (CE) experiences in health care education has been debated for decades.¹⁻⁷ In recent years, discussion about payment for CE experiences in physical therapy education has grown, with some clinical organizations implementing, or stating an intent to implement, a charge for providing CE experiences.^{4,7,8} Primary reasons for CE sites requesting payment include expenses related to students, such as onboarding and other administrative activities, and potential or perceived decreases in productivity of the physical therapist (PT) serving as a clinical instructor (CI).^{4,5,7,8}

The financial burden of payment for CE experiences in physical therapy is concerning for many stakeholders. Paying for CE experiences may disadvantage schools with smaller financial reserves,⁵ and many universities were experiencing financial shortages even before the coronavirus (COVID-19) pandemic.⁹ Although this study was conducted before the pandemic, since the pandemic's arrival in the United States (US), anecdotal information reveals that transitioning classes from brick and mortar buildings to an online platform is costing universities hundreds of thousands of dollars for resources, such as site licenses for teleconferencing platforms, faculty and staff training, and other online transitional expenses. As universities transition back to campus, other costs are being considered, such as air filtration systems, screening systems, personal protective equipment, and faculty and staff training.¹⁰ The University of Wisconsin–Madison estimated a \$100 million loss from the effects of COVID-19. Potential losses in revenue from decreased enrollment were not factored into this calculation.¹¹ Given these factors, payment for physical therapy CE experiences will likely create additional increases in the cost of education for students. Discussions regarding student debt in PT education have risen to the forefront as recent publications report staggering amounts of debt carried by PT graduates.^{9,12-15} The average student debt for PT education ranges from a low average of \$83,000 to a high average between \$100,000 and \$124,999.¹²⁻¹⁵

Concerns about payment for CE experiences and its potential impact on student debt led the American Council of Academic Physical Therapy (ACAPT) Board to charge the National Consortium of Clinical Educators (NCCE) to examine the issue of payment for CE experiences and to formulate recommendations. The Task Force (TF) on Payment for Clinical Experience began work in 2017 and solicited input from a broad spectrum of stakeholders. The aims of the TF were the following: (1) describe existing economic models of CE, (2) identify advantages and challenges of each model, (3) examine cost structures already in place in other professions, (4) explore ethical and legal implications of payment for clinical experiences, and (5) identify academic and student expectations when payment for clinical experiences was required.

REVIEW OF THE LITERATURE

The purpose of the literature review was to investigate historical and current literature regarding how various health care disciplines were conducting the clinical experience components of their training/curricula, regarding the above four aims. A series of reviews of literature occurred during the years 2018–2020 and encompassed research studies including topics related to payment for CE and the above aims. In addition to the field of physical therapy education, other health care disciplines were included, such as occupational therapy, dentistry, physician assistant (PA), medicine, midwifery, nursing, and

pharmacy. The following databases were used: Scopus, CINAHL Complete, PubMed, and PsycINFO with no date limits. Google Scholar and other secondary references were also reviewed. Combinations of various key words were used to search the literature and included: “clinical education,” “field work,” “internship,” “clinical instructor,” “preceptor,” “models,” “benefit,” “incentive,” “pay,” “payment,” “reimbursement,” and other related phrases and terms. All articles included in this literature review were available in English.

Articles including concepts of payment for CE experiences and benefits and challenges to serving as a CE site or instructor were retained. The TF conducted reviews of the full-text articles using a structured process. Each article was summarized and categorized by research design, discipline, methodology, factors assessed, outcome measures, and results. Critical appraisal of each article outlined areas of weakness and TF members identified specific concepts to replicate in the future investigation. The literature review produced a total of 59 articles (Figure 1) and served to inform the survey development process that will be presented in part 2 of this work. The authors provide a thorough synopsis through this literature review.

Definition of the Problem

Clinical education is an essential component of every Doctor of Physical Therapy curriculum that provides students with hands-on interactions with real patients in authentic clinical settings. These clinical experiences are

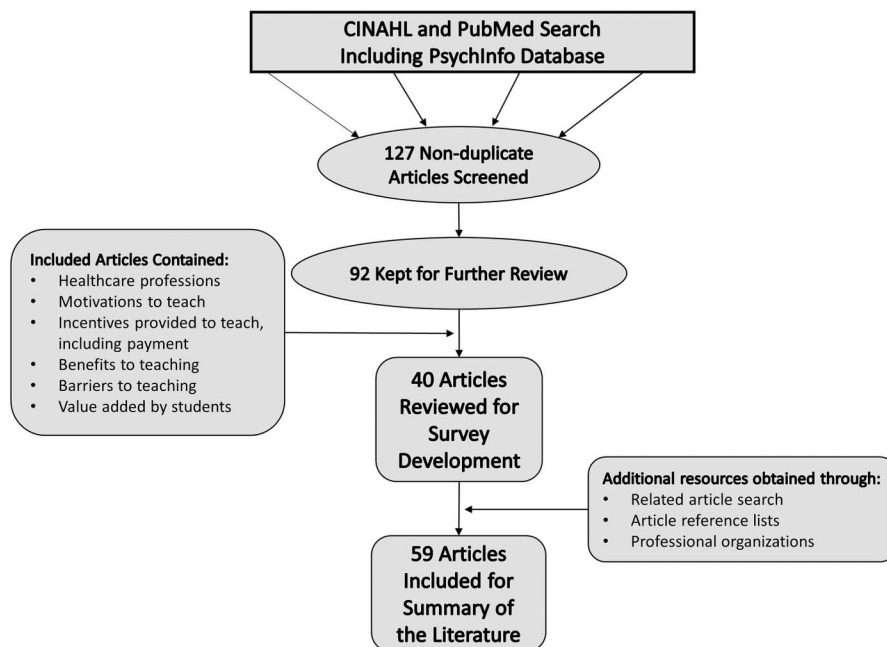
vital for development of clinical reasoning and problem-solving skills required of a competent health care professional. In addition to these essential skills, the CE process allows for formative development of technical and nontechnical skills.^{16–18} Often when students struggle with CE experiences, it is in the realm of nontechnical skills, such as communication and professional behavior.¹⁸ Growth and development of the budding professional student require that students experience all the tasks, roles, responsibilities, and challenges associated with competent PT practice. These authentic clinical experiences cannot be effectively duplicated in a classroom or laboratory setting.

The burden on health care facilities to provide these CE experiences is growing yearly with every developing physical therapy program and every increase in a program’s class size and number of required CE weeks. According to the 2019–2020 Commission on Accreditation of Physical Therapy Education (CAPTE) Fact Sheets, there were 258 CAPTE-accredited PT programs and an additional 11 programs in the development stage.¹⁹ Of 34,202 students enrolled in PT programs, the mean class size was 41 students in public programs and 48 students in private programs. According to recently published studies, the number of full-time CE weeks varied by program and ranged from 30 to 56.6 weeks comprising between 29%²⁰ to almost 50% of the PT curriculum.²¹

This rising burden is exponentially compounded because, in addition to physical therapist assistant (PTA), occupational therapist (OT), and occupational therapist assistant (OTA) students, many other health care, and even pre-healthcare, students are seeking CE opportunities. During the supervision of PTA students, as in all aspects of care delivery, the PT is directly responsible for the actions of the PTA and the PTA student in all practice settings.²² In addition, PT practice act or rules in many jurisdictions stipulate how many individuals a licensed PT may supervise, which typically includes PTAs, technicians, and students (PT and PTA). For instance, the rules for the state of Louisiana [RS 37: 2418(F)(2)(a)] state “it is the responsibility of each PT to determine the number of individuals he can supervise safely and within the ratio set forth by law,” and “in no case shall the number of individuals supervised by a PTA on any given day exceed two, nor exceed the following limitations: no more than two PTA students.”²³ These types of limitations also restrict the usage of the collaborative model of CE as described by Ladyshevsky.²⁴

In 2002, the American Physical Therapy Association (APTA) reported that the top reasons clinical sites cancelled student

Figure 1. Literature Review Process



placements were staffing changes, issues with reimbursement, insufficient staff with adequate experience, and productivity demands.²⁵ The APTA report also noted that in 1999–2000, over 15% of CAPTE-accredited physical therapy schools in the US changed their setting-specific requirements for CE experience due to an inability to obtain enough clinical placement offers in some settings. Further, 15% of students were not didactically prepared for the setting in which they were placed, and over 10% had CIs who did not meet recommended standards of preparedness.²⁵ This problem has only grown as the demand for health care professionals has escalated in recent years.⁴ New programs are being developed and existing programs are increasing class size to admit more students to meet this growth in demand.

Other health care disciplines note similar and disparate reasons for reluctance to supervise students. These reasons include lack of resources, lack of or variation in student preparation, productivity standards, demands on time, lack of professional behavior in students, low patient census, and concerns about knowing or following legal and reimbursement rules.^{4,26-29} In a study of PAs, some PAs perceived the workload of faculty clinical coordinators impeded clear communication between the schools and the clinical sites, resulting in fewer sites willing to take students.²⁹ Similar to physical therapy education programs, PAs in that study also reported rising numbers of health professional students, inadequate numbers of clinical sites, and space and workload constraints created challenges in accepting students.²⁹

The growth in workforce demand, along with development of new PT programs and increases in class size in existing PT Programs, has led to an increase in PT students. However, the number of clinical sites willing and able to take students for CE experiences has not kept pace.⁴ As the number of students grows and the challenges related to providing these experiences also increase, student exposure and meaningful participation in many areas of practice is increasingly limited. Anecdotally, available opportunities in both the neurorehabilitation setting and the acute care setting are increasingly difficult to obtain. Many inpatient environments are further restricted by risk management strategies related to the COVID-19 pandemic, such as social distancing requirements and limiting personnel to only those that are considered essential to providing care. Issues related to the Health Insurance Portability and Accountability Act (HIPAA), access to electronic documentation, Medicare and Medicaid regulations that limit or prohibit reimbursement for student-

delivered care, and space limitations all serve to potentially affect the availability of CE opportunities. Costs related to onboarding and administrative tasks and productivity concerns for the supervising therapists may negatively affect a clinical facility's willingness to provide CE experiences.

Costs of Providing Clinical Education Experiences

Although there is much discussion from academic and clinical perspectives about direct and indirect costs of providing CE experiences, the physical therapy literature is limited regarding these costs. Research conducted outside the US and by other health care professions provides some insight. Page and MacKinnon³⁰ reported that physical therapy CIs from 12 regional health facilities in the University of British Columbia system spent over 10,200 hours supervising students during a 1-year period. These hours included direct and "joint purpose" educational time with students and established an awareness of the amount of time needed by CIs to train students. Calculations at that time indicated the cost to the health care environment of accepting one student for an average of 9 weeks was \$2,223, which was a significant cost to the clinical facility hosting the student.³⁰ Anecdotally, clinical sites note that administrative and onboarding costs related to the management of the CE process also limit their ability to take students. Investigations in medicine and nurse-midwifery also report costs for supporting CE experiences. Previous studies^{31,32} determined that hosting a medical student for training could cost the clinical facilities \$100–\$200 per day. Nurse-midwifery preceptors in the US reported spending about a half hour per day on CE activities, including discussion with the student or school faculty and filling out paperwork for evaluation of the student.³³ This estimate of preceptor time was combined with the approximate number of student clinical days and the average salary of a preceptor to calculate an estimated cost of \$1,727 per student per year for providing educational activities.

A similar pattern of time requirements is seen in medicine. Peters et al² reported that patient encounters were approximately twice as long for primary care physician preceptors when a student was present, resulting in fewer patients being seen or the physician's workday being longer. Other authors reported increases in operation costs ranging from 30% to 40% when compared with practices that do not accept students.^{31,34} Drowos et al³⁵ identified the primary barrier to taking medical students was time constraints. Training practitioners to work with students requires time from the

faculty and practitioner, and once the student is in the clinic, additional time is needed for the clinician to feel that the student is effectively and efficiently managing patients.³⁵ Whether through an extended workday or decreased patient census, health care professions describe estimated costs to the clinic site.

Productivity and Students

As reimbursement rates for health care services plummet, productivity and accountability when providing these services becomes increasingly important. This literature review did not find studies that directly reported areas of cost of providing CE in physical therapy, such as salaries and time commitments for the site coordinators of clinical education (SCCE) who manage the CE programs. However, productivity of the CI has been reported. In their 1970 publication, Ramsden and Fischer³⁶ concluded that about 40% of a CI's time was spent on patient care that generated payment while another 40% was spent providing patient care that was not billable. This finding is antiquated in today's environment as health care entities have adjusted business models to limit employee time performing activities that are not revenue producing.

While productivity demands have changed with our evolving health care system, most literature published in the past two decades shows that productivity is not affected and may actually be enhanced in certain practice areas by the presence of students.^{9,20,26,37-41} As early as 2003, Dillon et al³⁸ reported that supervising PT students for clinical training increased productivity in an acute care and rehabilitation center. Anderson and Newstead⁴⁰ studied the productivity of five CIs in a single skilled nursing facility from 7 weeks before the start of the CE experiences to 7 weeks after the experiences ended. The researchers found increased productivity rates for four of the five CIs when the students were present compared with the 7 weeks preceding the CE experience, and this increased productivity extended through the 7 weeks after the student experiences ended.⁴⁰ Pivko et al³⁹ also studied the impact of PT students on productivity in a variety of physical therapy clinics in states across the US, including both inpatient and outpatient settings, by analyzing productivity logs for 34 CIs and their PT students who were completing CE experiences. These authors report that productivity significantly increased as measured by number of patients seen and number of charges billed.³⁹ This increase in productivity was even greater when students were present in the clinic for at least 8 weeks.³⁹ In addition, the increase in productivity was seen for students on their first

and final clinical experiences, with no significant difference in productivity between the two levels of experiences.³⁹

Pabian et al⁴¹ analyzed the productivity of 20 PTs with and without PT students in an acute care hospital setting during a 3-year period. They also studied whether the collaborative model of CE (more than 1 student per each CI) as described by Ladyshevsky,²⁴ in 1995, had an impact; CE experiences ranged from 6 to 18 weeks in length.⁴¹ Similar to other research in acute care, the authors found that PT productivity increased during a 1:1 and a 2:1 model; the 2:1 model generated an average of 4.48 units more than the 1:1 model and 4.85 units more than therapists without a student.⁴¹ A 2020 study by Apke et al²⁰ retrospectively examined CI productivity across 3 years in acute care, inpatient rehabilitation, outpatient orthopedics, and outpatient neurorehabilitation settings. The authors reported that CI productivity significantly increased in outpatient orthopedic and inpatient rehabilitation settings.²⁰ During the CE experience, PTs with a student in all settings except acute care were more productive than their colleagues who did not have a student.²⁰ Although the presence of students made CIs more productive, there was no negative effect on the productivity of other therapists who did not have a student.²⁰ This finding may ease concern that other PTs in the facility may have to “pick up the slack” for the CIs.

While some studies showed an increase in CI productivity, a study of 109 OT students in inpatient rehabilitation, outpatient rehabilitation, and pediatric settings at a single institution in the Midwest found no significant difference in productivity for 56 OTs serving as a CI whether they had a student.²⁶ However, this study also exposed a difference related to settings and students and productivity.²⁶ Clinician–student pairs in the outpatient setting were less productive than those in the inpatient rehabilitation or pediatric settings.²⁶ Recker-Hughes et al³⁷ surveyed 293 directors of clinical sites in New York and New Jersey who accepted students from three PT programs. Most directors (77.6%) reported that the student CE program did not affect or increased productivity. Even a higher percentage of directors (93.6%) reported that the quality of care delivered at their institution improved or was not affected by students being involved in the care of patients.³⁷ In addition, the respondents stated that students contributed to staff professional development (90.4%), professional obligations (84.0%), and the facility’s mission (80.9%).³⁷ The student program also helped with clinical site recruitment (71.9%).³⁷ Overall, students enhance clinician productivity in various settings while

also bringing added benefits to the individual CI and clinical environment.

Motivating Factors and Incentives for Supervising Clinical Students

Several authors^{2,42,43} reported various factors, both monetary and nonmonetary, that motivate supervisors to accept health care students for CE experiences. While payment may incentivize individuals to offer CE experiences, many nonmonetary benefits are known. Preceptors of primary care student physicians from Harvard Medical School rated “having a good student” as the reason that most influenced their decision to continue taking students; 73% of preceptors rated this as their top response.² Only about 8% of preceptors listed payment as the top reason to continue taking students.² When preceptors were asked what contributed to their teaching role satisfaction, 82% of the preceptors rated having a good student the highest contribution to satisfaction, and no one rated the stipend as the highest source of satisfaction.²

When Latessa et al⁴² surveyed 1,428 community-based primary care preceptors in North Carolina (physicians, pharmacists, advanced practice nurses, and PAs) about factors that affected their willingness to supervise students, the highest valued incentives were library resources and continuing education credits; compensation was ranked fifth. In a follow-up study investigating the same population of preceptors, Latessa et al³ found that a majority of the preceptors felt positive about the incentives they received for teaching students in the clinic. Financial compensation was an incentive in this later study; however, participants also indicated they valued credit for continuing education, the provision of CE topics, and academic appointments.³ The most highly valued incentives were continuing education credit for teaching (86.5%), continuing education programs on clinical topics (72.9%), free online library resources (72.1%), academic appointments (65.9%), and financial compensation (61.9%).³

Occupational therapists also place value in similar factors; OT Level II fieldwork supervisors from Florida and North Dakota identified factors positively influencing their decision to accept students.⁴³ The 500 respondents indicated continuing education units, memories of their own fieldwork experiences, the ability to share supervision duties, and access to education resources as positive influences.⁴³ In a physical therapy study, site directors described the most meaningful benefits for their CIs supervising students.³⁷ The top five benefits identified by the respondents were discounted or free continuing education courses (97%), continuing education units for supervising students (95%), discounted or free CI credentialing

training (91%), and discounted or tuition-free college courses (89%).³⁷ These benefits for providing CE experiences are commonly noted among all health care professions.

Support of the profession, as noted by Latessa et al,³ is highlighted in other research as an incentive to provide CE experiences along with individual professional development. During focus groups discussing fieldwork, OTs reported that they accepted students mainly to foster their own growth and give back to the profession.²⁸ In a study of midwives, respondents indicated positive motivators of continuing education, preceptor training, textbooks, recognition, and faculty appointments as reasons to take a student, but the most common reason was to support the profession.²⁷ In a qualitative study that included interviews with 18 physiotherapists in Canada, Davies et al⁴⁴ found that a recurring theme was the concept of “giving back” to the profession. A study in 2011 investigated the opinions of Australian physiotherapists about their perceptions of CE as a component of their practice.⁴⁵ Of those who participated, 89% indicated that CE was a core role of their profession.⁴⁵ The physiotherapists consistently reported that principal motivation for delivering CE was duty or responsibility, an intrinsic factor recognized previously.⁴⁵

Students also bring value to the CE experience. In a survey of employers at clinical sites providing CE experiences to health professions students, respondents indicated that students provide information about current trends and research, enthusiasm for the profession, and a differing perspective.⁴ Students also provided clinicians with the ability to improve supervisory skills and work on administrative projects.⁴ Although studies investigate the value of serving as a CI and intrinsic motivators for providing a CE experience, little research explores the benefits related to cost gains and savings by hosting student learners. In one study, providing CE experiences translated into recruitment benefits.⁴ Fagerlund and Germano³³ noted two quantifiable benefits to clinical practices were an increase in the provision of patient services and decreased recruiting costs for certified nurse-midwives. This increase in patient care added a value of \$5,180 for each student annually.³³ The authors noted that there is the potential for \$25,000 in savings for each student hired directly from a CE. This saving is based on reduced advertising, interviewing, onboarding, and training costs.³³ Although most research consistently demonstrates intrinsic motivation and benefits other than compensation for providing CE experiences, reimbursement for CE experiences is still seen in health care professions.

In summary, physicians valued intrinsic reasons for precepting, such as enjoyment derived from mentoring students (particularly “good” ones), giving back to the profession, and intellectual stimulation, at least as highly as extrinsic rewards.³ Pharmacists, advanced practice nurses, and PAs placed significantly more importance on being a role model than physicians.³ Free or discounted continuing education access to libraries and other education resources were among the strongest extrinsic motivators for PTs and OTs, whereas giving back to the profession and influencing future practitioners were among the strongest intrinsic factors.^{37,43}

Financial Reimbursement and Compensation

Although uncommon in occupational and physical therapy, financial incentives offered to or requested by CE sites or clinical educators are provided by or requested from some academic health care profession institutions. A study in occupational therapy highlighted that some sites receive compensation for welcoming students²⁸; in physical therapy, sparse and dated literature exists regarding payment for CE. In 1988, Holder⁶ surveyed 43 schools and colleges of allied health, which included 274 programs, about payment for CE experiences. Only 2.2% of academic health center programs and 10.6% of college of health programs reported paying the site for CE experiences.⁶ None of the payment was directed toward physical therapy.⁶ Of all survey respondents, only 6.2% indicated paying individual CIs directly.⁶ Wetherbee et al⁷ interviewed 33 PTs who were CIs and/or SCCEs and reported perspectives on current CE issues and challenges. Their participants suggested that providing financial incentives would offset perceived expenses incurred by the clinical site during clinical experiences.⁷ Participant comments included the following: “offer extra pay,” “reimbursement and/or tuition vouchers,” “sharing of [student] tuition dollars,” and “student tuition money should go from the academic institution to the clinical facility, not to the CI.”⁷ One individual bluntly stated “you give us dollars and we’ll give you clinical spots.”⁷ With limited research in occupational and physical therapy, most of the current review explores monetary compensation for supervising students in PA, medicine, and nursing.

Paying preceptors for PA, medicine, and nurse practitioner student CE experiences is now the norm rather than the exception according to Randy Danielsen,⁴⁶ PhD, PA, DFAAPA, editor-in-chief for *Clinical Reviews*, a peer-reviewed professional journal for PAs and nurse practitioners. The cost of

paying preceptors rolls over into increased fees or tuition for the student. The issue of whether the preceptor or the institution receives the compensation and the amount of compensation itself can be an issue and may create “bidding wars.” In medicine, Harvard University paid various amounts to preceptors for student CE experiences over a 19-year period.² This stipend started at \$600 and increased to \$2,500 during that period.² The increased stipend was used to attract and retain more preceptors; the authors reported that the higher stipend resulted in better retention rates for preceptors.² In addition, retention was significantly associated with preceptors receiving compensation directly rather than their company.² Further, medical student supervisors indicated that stipends were “a concrete indication that one’s time and energy are valued” and were a mechanism for the school administration to convey appreciation for effort and compensate for lost revenue.² In another study, 53.1% of physicians reported that fair compensation would be more than \$150 per week, and 32.5% of pharmacists, 35.2% of advanced practice nurses, and 26% of PAs reported similar opinions.³ The amount and frequency of payment varies in health care professions in the US but may be less frequent than in other countries. Drowos et al³⁵ reported that only 28% of US family medicine clerkship directors were paid, but 100% of their Canadian counterparts were paid. Further, the authors determined for those programs that paid their community-based faculty for clinical supervision activities; the average payment to the practitioner was \$263 per week.³⁵

As discussed above, payment in PA, nursing, and midwifery is more frequent than in occupational and physical therapy. Brown⁴⁷ reported that, in the field of nursing, some clinics charged a minimum of \$200 per week for a practicum experience, which translates to \$1,600–\$2,000 for an 8- to 10-week session. In a study of over 1,500 nurse-midwives, Germano et al²⁷ reported that 37.8% of midwife preceptors received compensation for taking students. However, less than 1% of respondents who were not paid said that they were not taking students for this reason.²⁷ In addition to the cost increases over time, the number of programs paying has grown as well.² The number of PA programs that reported paying for some or all clinical experiences rose from 22.3% in 2012–2014 to 48.3% in 2017–2018.⁴⁸ A small number of institutions (13.6%) paid every clinical site that mentored students, but the majority only paid some of their clinical sites.⁴⁸ The average payment given to clinical sites in 2017–2018 was \$326 per week per student for public institutions and \$232 per student per week for private institutions.⁴⁸

Christner et al⁴⁹ surveyed community-based physician preceptors who accepted direct compensation to supervise medical students. The authors expressed concern over potential dilemmas with current norms by challenging whether people should continue to “work for free” and suggesting that direct compensation was “the right thing to do.” Preceptors were now viewed as “commodities” who no longer cared about the intrinsic benefits of teaching, and students were “viewed as extra revenue” rather than learners.⁴⁹ The authors urged institutions to set clear expectations for preceptors who are directly compensated to maintain a healthy and productive learning environment for students.⁴⁹

Considerations When Paying for Clinical Supervision

Ethical Considerations. One of the 8 APTA Core Values is duty, which is defined as “the commitment of meeting one’s obligation to provide effective physical therapy services to individual patients and clients, to serve the profession, and to positively influence the health of society.”²² Previous definitions from the APTA described this value as professional duty and included examples, such as “involved in professional activities beyond the practice setting” and “mentoring others to realize their potential.”²² Concepts such as giving back to the profession, acting as a role model, paying it forward, and providing training experiences similar to those experienced as a student are used to express the motivating factors that influence PTs to want to mentor students and are embedded in our profession’s Core Values. Requiring payment for such activities may be contrary to the disciplines’ professional ethics.

A study by Glavaz et al⁵⁰ suggested that the practice of paying clinical supervisors may be contrary to the professional ethics of the PA profession. Sixty-nine percent of PA program directors in the study felt it was unacceptable to pay preceptors and 91% of these program directors felt that the education of PA students in the clinic should be a “give back to the profession” without expecting financial compensation.⁵⁰ In her dissertation, Begley⁵¹ reported a “stigma” associated with payment for CE in the PA profession because most PAs feel that participating in CE as a preceptor should be intrinsically motivated. Physicians teach students for personal satisfaction and professional growth, without concern for payment.⁵²

Although serving the profession and mentoring others support the professional ethics of health care disciplines, payment for CE experiences continues to be a topic of

consideration. O'Brien et al⁴ conducted interviews with 21 education directors who were specifically suggested by deans of the Association of Schools Advancing Health Professions (ASAHP). The researchers sought to better understand the benefits, obstacles, and evolving issues related to allied health CE from the employers' perspective. The interviewees expressed concern about payment to clinical sites or preceptors for providing CE opportunities.⁴ Further, the participants believed that the practice of paying preceptors was unsustainable for educational institutions that provide affordable health care education.⁴ According to a recent study, 65% of program directors in medicine and PA education reported feeling pressure to pay clinical sites for CE.⁵³ As health care professional programs increase in both number and size, the need for CE experiences continues to grow as well.

Payment and Quality. Literature is limited regarding the relationship between quality of a CE experience and payment incentive. Only the disciplines of medicine and PA training appear in the literature and the authors' conclusions differed. To determine whether financial incentive had an impact on student experiences, Ashar et al⁵² reviewed student evaluations of paid and unpaid preceptors, comparing them with two different time frames: during periods when preceptors were not paid to years when they were. The Johns Hopkins University School of Medicine implemented a program in 2005 that supplemented the salary of physicians by 19% for those advising students and acting as instructors in the clinic.⁵² During the 2003–2005 academic years, the preceptors were not paid.⁵² During the 2005–2006 academic year, only physicians who had this increased salary supervised medical students.⁵² When comparing evaluations of the preceptors, students rated the preceptors who taught them in the 2005–2006 year significantly higher.⁵² For the seven preceptors who supervised medical students during both periods, there were no significant differences in ratings when the preceptors were volunteers or when they were paid.⁵² Other than these seven preceptors, the demographics of the paid and volunteer preceptors were different: the paid preceptors were more likely to have an appointment with the university, have an advanced degree, and participate in training on teaching provided by the university.⁵² The authors concluded that financial compensation for clinical teaching was associated with higher student evaluation. In contrast, Begley⁵¹ found that payment did not significantly improve PA student CE quality. Similarly, nearly 82% of PA program directors reported

that payment for CE did not lead to higher quality of instruction.⁴

Regulatory Considerations. The ASAHP Clinical Education Task Force found that program directors were concerned that payment to clinical sites by for-profit educational programs may place nonprofit educational programs at a competitive disadvantage.⁵ Because of increasing regulatory constraints, more facilities are cost-sharing with students or their institutions. Expenses that are commonly incurred by the student may be related to onboarding processes, such as background checks, application and tracking fees, immunizations and drug screens, access to electronic medical records, and site-specific resources like identification badges and parking.⁵ Glavaz et al⁵⁰ found up to 40% of PA programs that pay for CE experiences pass the cost on to students through increased tuition or fees. Health care programs must recognize the potential detriment of shifting costs onto students and the impact that may have on student recruitment. Agrawal et al⁵⁴ expressed concern about the negative impact increasing costs have on underrepresented populations of students, stating that “high educational costs are especially detrimental to the diversification of the health care workforce, as increased costs create significant entry barriers to health care professions for students of color.”

Impact on Student Debt. Rising student debt, in general and in health care education, is alarming to many. Since 2006, student loan debt in the US has more than tripled; as of the third quarter of 2019, it was over \$1.6 trillion.⁵⁵ For 2015–2016, the National Center for Education Statistics reported that the average debt incurred to obtain a medical degree was \$246,000 for physicians (allopathic and osteopathic) and that the average debt for other health science professional practice doctoral degrees was \$202,000.⁵⁶ In comparison, a doctorate in education incurred an average of almost \$112,000 of cumulative student debt.⁵⁶ According to Chisholm-Burns et al,⁵⁵ in 2016, the average student loan debt was \$229,000 for dentists, \$163,000 for optometrists, and \$157,000 for pharmacists. According to the Organisation for Economic Co-operation and Development, the average postsecondary tuition costs are greater in the US than in almost any other of its member countries.⁵⁵

Today's PT graduates leave school with an average of more than \$83,000 in student loan debt.¹⁵ In 2018, Shields and Dudley-Javoroski¹² reported that the debt of recent PT graduates had increased to an average \$86,563. Amble¹⁴ collected data from 86 PT students in Florida; the most frequently reported range for PT graduate debt and total educational

debt was \$100,000–\$124,999. Shields and Dudley-Javoroski¹² also reported that student debt for PT students was higher than occupational therapy, optometry, veterinary medicine, and chiropractic students but lower than dentistry, pharmacy, nurse practitioner, and PA students. These authors advised caution and encouraged assessment of financial impact before pursuing a PT degree.¹² Pabian et al⁹ agreed with this finding and suggested that students pursuing PT degrees should weigh the debt primarily from high costs of education with the minimal earning potential early in their careers.

In 2016, Jette¹³ provided an overview of student debt for those students pursuing a Doctor of Physical Therapy degree. Citing Quinterno,⁵⁷ a research and communications consultant specializing in economic and social policy, a 210% increase in tuition and fees at 4-year universities and an average 130% increase at similar private institutions was reported. Jette¹³ urged CAPTE and the Federation of State Boards of Physical Therapy to address the student debt issue, suggesting that these groups reward “innovative methods for reducing costs” and encourage more efficient ways to train professionals. One such suggestion was to reduce the number of CE courses, particularly the number of times that PT students must travel out of town for these experiences.¹³ Such a change may result in decreased costs for travel; housing costs would also decrease with a reduction of required CE experiences. A minimum of 30 full-time weeks of CE are required per CAPTE's Standards and Required Elements for PT Programs.⁵⁸ According to the 2019–2020 CAPTE Fact Sheets, the number of full-time CE weeks included in PT curricula ranges from 30 to 56.6 weeks.¹⁹ Accreditation standards for CE experiences certainly allow for the decrease suggested by Jette in 2016.¹³

To our knowledge, there is no published literature that describes how paying for CE experiences adds to student debt; the Physician Assistant Education Association reported payment for supervised clinical rotations typically increased the cost of education for PA students by \$12,000–\$15,000 per student.⁵³ From a survey about clerkship experiences, the sources of funds for clinical site placements were increased tuition (42%) or students' fees (30%).⁵³ Although there were no studies identified that addressed how CE costs may add to PT student debt, it is likely that the adverse effects noted in the cost of PA education may similarly affect PT students.

CONCLUSION

Payment for CE experiences and its impact on student debt seem to be the result of a perfect

storm of rising numbers of PT students caused by a proliferation of PT (and PTA) programs, expanding class sizes, and an increasing number of CE weeks required by individual programs. The 2019–2020 CAPTE Fact Sheets stated that there were 34,202 students enrolled in PT programs nationwide.¹⁹ This represents a 3-fold increase in the number of students enrolled in PT programs over the past 15 years. Commission on Accreditation of Physical Therapy Education reported that there were 11,694 PT students in the US in 2004–2005 and 23,360 in 2009–2010.⁵⁹ While the number of physical therapy students almost tripled in 15 years, the number of PTs employed in the US has not even doubled in that timeframe.⁶⁰ There were 145,210 persons employed as PTs in the US in 2004, and there are 258,200 persons employed as of September 2020.^{60,61} In addition, the minimum number of weeks for full-time CE increased during this same timeframe. In 2009–2010, the minimum number of weeks of full-time CE in PT education was 20 weeks.⁵⁹ Currently, CAPTE mandates that all PT programs have a minimum of 30 weeks of full-time CE.⁵⁸ The increase in number of PT students and number of full-time CE weeks increases demands on clinical sites.

Adding to the PT student CE burden articulated by clinical sites are comparable requirements in other disciplines, such as occupational therapy or undergraduate kinesiology and other students. The sheer number of students requiring clinical experiences coupled with increased regulatory requirements related to onboarding, for example, HIPAA, background screening, and training, are of grave concern to clinic directors. Productivity demands related to reimbursement pressures also contribute to this issue.

SIGNIFICANCE AND NEXT STEPS

Payment for CE experience in any health care profession is a complex topic with many stakeholders to consider. The current comprehensive literature review covers many factors, challenges, benefits, and considerations related to payment for CE experiences; information specific to physical therapy related to payment for CE experiences is lacking. This literature review indicates that more information is needed about the current state of payment for CE in physical therapy, including its prevalence, specific payment per student, and source of funding for payment. The cost of CE to the clinic and student obligations if CE was an additional cost also need to be explored. Barriers to accepting physical therapy students in the clinic setting, as well as the perceived benefits of providing

clinical experiences to physical therapy students, are other topics requiring investigation.

The aim of the TF on Payment for Clinical Experience was to explore the opinions of various stakeholder groups involved in CE to determine current perspectives, and actual and potential practices related to payment for CE in PT education. This literature review guided the TF in survey formation and development of informed, comprehensive questions appropriate for specific CE stakeholders in PT education. Survey questions and answer options were drawn from concepts discovered in the literature review. The survey development process, results of the survey, and conclusions based on the data collected are presented in part 2.

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