A Professional Doctorate in Clinical Laboratory Science?—Not so Fast

GEORGE A FRITSMA

I'm delighted to read Dr Kathy Doig's editorial, "The Case for the Professional Doctorate in Clinical Laboratory Science (DCLS)". As a practitioner and educator, I support every effort to elevate our profession. Further, Dr Doig is a professional acquaintance and friend whose opinion I respect.

Nevertheless, my self-appointed task is to poke holes in her proposal. Like most clinical laboratory scientists (CLSs), I work closely with clinical pathologists. The UAB Division of Laboratory Medicine employs eleven MDs, five with concurrent PhDs, and five non-MD PhDs; sixteen altogether. Of the five PhDs, two are microbiologists and three biochemists. One of the biochemists is a CLS. The whole pathology faculty (clinical, anatomic, and experimental) numbers 78.

At UAB, CLSs manage the laboratory in partnership with pathology. Our medical director, John A Smith MD PhD, calls it 'matrix management', an underused management approach. The pathology faculty draw on the CLSs as technical contributors to their practice, not as their employees—administratively, CLSs report to fellow scientists. A professionally favorable system, but with so many clinical pathologists around, CLS opportunities for rounding, committee work, and house staff interaction are limited. In fact, though they regularly attend rounds, anything the CLS may do that resembles consultation is discouraged—instead referring interpretations to clinical pathology faculty and residents. Why? They can charge for it under Medicare part B, the CLS cannot. UAB's PhD microbiologists and biochemists teach and consult frequently, however they are unable to charge through part B.

Not that the clinical pathology consultation system works all that well. Most clinical pathologist's consultation is 'curbside'. In the instances, let's assume three per day, when formal consults are actually requested and billed, they still have to collect. Except for platelet aggregometry, hemoglobin electrophoresis, lupus anticoagulant profiles, and a few analogous complex interpretations, there is little money to be made. In fact, the clinical pathologist has to hustle to keep the house staff's attention. So a pathologist may turn in 15 consults at the end of the week and collect $750. In hematology, reviewing an abnormal WBC differential is non-billable. It counts only as quality control. No wonder most pathology residents choose anatomic pathology, where each slide review generates consult fees. So in an academic health science center, where professionals draw on a thin supply of resources, few would welcome a DCLS who would provide consultation as a "value-added" (free) service.

How about smaller medical centers, for example, 400-bed community hospitals with active outpatient services? Here, the pathologist is certified in both anatomic and clinical pathology. She or he devotes 70% effort to the anatomic side, not just for the revenue, but because no one else can do it. Lacking broad clinical pathology experience, the pathologist avoids decision-making, and relies on the CLS for help.

The limitations here differ from those within the academic health science center. The contribution of a DCLS would be welcome, provided it didn't cost anything. Let's say the DCLS expects $75,000 a year. She or he would contribute nothing to bench 'production', so would have to justify the salary on the basis of cost analysis, utilization review, risk reduction, and outcomes assessment. Who does the analysis? The DCLS, using analytical skills that aren't readily available outside of a public health setting. Thus she or he would have to start with self-justification.

You and I know that she could prevent enough unnecessary ordering and adverse events to easily recoup $75,000, but it would be a hard sell, particularly if the pathologist already has access to the necessary information through the existing staff. What about the skills we more routinely identify with CLS, such as validation, quality assurance, precision, accuracy, and clinical efficacy? Valuable, but these skills are invisible to administration so long as nothing goes wrong.

Let's examine what is in-between: the 900-bed non-academic acute care medical center, where the pathology staff is more limited than an equivalently sized academic institution. Here, Dr Doig's proposal has a shot. She could probably justify a DCLS to fill a slot that would otherwise be filled by a clinical pathologist. The economics may work: the DCLS saves enough in utilization and outcomes to justify her

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$75,000, the laboratory director can pay less than a clinical pathologist's $140,000 (gross, not counting part B consult fees). Further it is as hard to find a clinical pathologist as it is a CLS. All that remains is for the DCLS to convince the house staff, nursing staff, other health professionals, and administrators that she is worth listening to. While MDs and nurses are comfortable with 'their own kind', they will listen to any professional who knows what he is doing and keeps them out of trouble. It's a matter of trust. Once the team recognizes the value of the DCLS, she is in.

Higher education is perhaps the most promising DCLS opportunity. Universities insist on doctorally prepared faculty, and anyone who reads the discussion boards knows we need more. There are too few CLSs with doctorates in related sciences such as pathology, microbiology, pharmacology, biochemistry, or education to fill the pipeline. Indeed, in their haste to fill positions with PhDs, universities have taken the questionable step of employing non-CLS PhDs, scientists who can ostensibly write grants but who possess a peripheral knowledge of the profession; a short-term, often damaging solution. Conversely, a DCLS in education would have to have a competitive and sustained research record.

The final possibility is the in vitro diagnostics and the reference laboratory industries. Employing business models, instrument and reagent manufacturers perceive the need for professional spokespersons to address clinical customers. Reference laboratories and pharmaceutical distributors are also moving in this direction. There is little tradition, but a growing trend toward physicians and non-CLS PhDs. The DCLS would be an excellent fit in this niche, but would have to prove their worth.

In the end, the DCLS concept could work if we:

- find a way to create acceptable communication among DCLS, medical, surgical, pharmacy, and nursing practitioners.
- estimate the number of potential DCLS positions and learn who currently occupies them.
- develop a welcome for the DCLS in positions currently occupied by clinical pathologists and PhD basic scientists.
- develop a business plan to illustrate that a DCLS will be productive enough in cost analysis, utilization review, outcomes assessment, and risk reduction to be fiscally attractive to all size institutions.
- assess the potential for establishing DCLS research tracks that fit within the higher education structure.
- market aggressively.

George A Fritsma MS MT(ASCP), Continuing Education Editor.

Decisions, Decisions, Decisions

SUSAN LECLAIR

We live in a world with simply too many of them. In the latter half of the last century, the wish was for choice. Now that we have it, we have come to the realization that choice demands decision making. And so we choose sometimes after thoughtful consideration, sometimes with no thought what so ever.

In the world of decision making, one can see the choice as one of duty. Admiral Farragut's order "Damn the torpedoes…Full speed ahead." is a decision borne of duty. But one can also see choice as a matter of consequences. How many times has someone said, "The greater good for the greater number." A person who is consistent in their approach to life chooses only one of those principles. As we all know, humans are rarely consistent in their decision making.

The House of Delegates makes decisions for the society and ultimately then for the profession. Some years those choices seem to be less onerous than other years. This year there will be discussion and debate about many things but one of the choices will be about the future of the profession. There will be a position paper concerning the creation of a new practitioner and the development of a new way of educating them.

Where do you stand on the question of a doctorate in clinical laboratory science? What would you be able to do with it? Who would pay for it? How would one get one? Who would be for it? Against it? The House of Delegates represents every member and therefore every member should be engaged in this conversation in order that the delegates reflect the understanding and will of the membership. In this issue there are two articles which explore the various aspects of this debate. You have a choice. Now all you have to do is make it.

Susan Leclair is Editor-in-Chief of Clin Lab Sci.

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