LETTER TO THE EDITOR

Clinical Doctorate in Laboratory Science

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I found the two articles concerning doctorate level clinical laboratory scientists (CLS) (Doig K, The Case for the Clinical Doctorate in Laboratory Science, Clinical Laboratory Science 2005;18(3):132-6, and Fritsma GA, A Professional Doctorate in Clinical Laboratory Science?—Not so Fast, Clinical Laboratory Science 2005;18(3):137-8), interesting and at the same time troublesome. The pros and cons of doctoral degrees in clinical laboratory science has been the subject of debate for the better part of the past 20 years.

This debate is akin to the chicken vs. the egg argument—which came first? Do we create doctoral CLSs (DCLSs) and have them go forth to find a purpose within the healthcare team or do we establish a purpose and then create DCLSs to fill the void? At this time we seem to have a potential product without a market.

The comparison between the role of the DCLS and the role of the PharmD is weak at best. The PharmD directly interacts with the clinician, nurse, laboratory, and patient in finding the right drug or combination of drugs to achieve a particular outcome. This is more than a consultative role. They are engaged in direct patient care.

The DCLS, as described, is a purely consultative role with the clinician, advising on the best test to order or providing interpretive information pertaining to the test results. Is this not the role of the clinical pathologist? In fact, I believe it is, but unfortunately it is not done well or consistently in many facilities which has been the subject of a number of CAP TODAY editorials.

I find little, if any, economic justification for the DCLS. In today's healthcare market of rising costs and decreasing reimbursements, there is little support for hiring costly personnel to provide non-billable services whose value has not been established. The value of the DCLS and the service provided must be determined by the user, who, to my knowledge, has shown little interest in using consultative services currently provided by the clinical pathologist.

The idea of a DCLS is a creation of the laboratory industry not the customer/physician. Physicians order many tests from the laboratory but rarely invite laboratory personnel/pathologists to assist them in their diagnostic decision making. This may not be ideal but it is reality, therefore what makes any of us think that a having a DCLS on the staff will make any difference?

I firmly believe the laboratory industry should be focusing its efforts toward increasing the market value of the CLSs in their role on the healthcare team. Overall the CLS's compensation has fallen well behind other professionals in healthcare. Personnel shortages are related to low salaries which encourage college students to look elsewhere for careers and newly graduated CLSs to look outside of patient care facilities such as industrial laboratories, marketing, etc. for greater rewards. The proliferation of degrees and certifications in the past 20+ years has not improved the compensation of laboratory professionals.

To make up for staffing shortages, clinical laboratories have installed significant levels of automation in the largest to the smallest facilities and consolidated with other laboratories or out sourced their work to commercial reference laboratories. This further depresses salaries; in some laboratories it reduces the need for CLS skill level practitioners, and discourages entry into the field. Can hospitals provide safe, quality healthcare without a professionally staffed clinical laboratory? If the answer is no, then it is high time to make the healthcare industry aware of the value of the CLS and what it will mean to patient care if these dedicated individuals are too few to provide the services necessary.

We are on the threshold of another explosion in testing methods and systems that will move from research and specialty laboratories to routine testing in the clinical laboratory. This testing will be more complex and initially less automated than current test methods. We will see even greater emphasis on faster turn around times to replace or supplement current processes such as culturing and batch testing. We will need skilled practitioners to manage, perform, and interpret the results of these new processes.

ASCLS, CLMA, etc. should be consumed with reversing today's downward spiral in which CLS practitioners find themselves and not spend time creating (or debating) a product (DCLS) for which there is no market.

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