

Professional Doctorate in Clinical Exercise Physiology

REBUTTAL: Time to Move Forward

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We appreciate the counterpoint provided by Dr Brawner; several of his highlighted points will be used to refine the development of the DCEP program and accumulate data from future graduates to provide greater clarity on employment, compensation, and clinical efficacy. It was also encouraging for us to read that many of Dr Brawner's points were similar to hesitations initially expressed by physical therapists (PTs) before and during transition to the professional doctorate of PT (DPT), which is now widely recognized to have elevated their professional status and ability to effectively and efficiently deliver services (1,2). In fact, many parallels can be drawn between the professional limitations faced by PTs before the creation of the DPT and today's clinical exercise physiologists (CEP). Prior to the DPT, the minimal entry level degree needed to practice as a PT was either a bachelor's or master's, which in time was viewed as a prominent barrier to achieving professional autonomy (i.e., ability to independently refer and bill for services) because of the relatively limited professional experiences acquired during these training models (1,2). The founders of the first DPT programs recognized that in order to achieve professional autonomy, the academic preparation of future practitioners needed to be elevated, supervised clinical experiences increased, and professional development courses expanded, allowing new graduates to assume and uphold the expectations of an autonomous clinician.

With the proposed DCEP program at the University of Illinois at Chicago being the first of its kind, empirical

evidence refuting Dr Brawner's concerns regarding the educational cost-to-salary ratio is not currently available and will only become apparent when surveying newly graduated DCEPs in the future. Until then, we refer to the early experiences of the PT profession. A salary survey taken close to the introduction of the DPT in the mid-1990s revealed that average annual salaries were positively graded across the bachelor's, master's, and DPT level (\$33,133, \$45,224, and \$55,000, respectively) (3). The latest salary survey performed by the Clinical Exercise Physiology Association also demonstrated a graded pay scale among entry-level bachelor's (\$38,751), master's (\$41,251) and PhD (\$71,251) prepared CEPs (4). Whether the salary for DCEP-prepared professionals follows the same trend as early DPTs is unknown; however, one can argue that the more robust clinical and professional preparation as well as the acquisition of certifications (i.e., Certified Diabetes Educator and Registered Diagnostic Cardiac Sonographer) through the proposed DCEP program will both improve patient care and provide additional lines of revenue for clinical departments. Collectively, entry-level DCEP-prepared CEPs would be able to take on greater clinical roles compared with the current bachelor's or master's prepared CEP, increasing the DCEP's marketability to clinical programs seeking CEPs.

Dr Brawner also accurately referenced the common theme of health care professionals moving toward the professional doctorate in order to practice independently while receiving reimbursement for rendered services and

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achieving direct access as is common across many health services, all of which are not possible for currently practicing CEPs. These points, coupled with the reference to the Association of Specialized and Professional Accreditors (5) on the call for developing professional doctorates in response to changes in complexity of practice, reinforces the need to move toward developing a professional doctorate option for CEPs. Broadly speaking, the clinical training and professional status of the CEP has been stagnant since inception of the clinical profession in the 1970s with cardiac rehabilitation. While there is no doubt that CEPs provide invaluable services that yield life-changing outcomes, compared with other allied health professionals that have quickly adapted to their changing environment, the CEP profession has remained relatively antiquated, making it difficult for recent graduates to find jobs in their primary area of interest. Dr

Brawner referred to the well-respected Henry Ford Cardiac Rehabilitation Program, which is made up entirely of CEPs. Unfortunately, their program's professional makeup is among the minority of cardiac rehabilitation programs, which was made evident from a previous survey that indicated a greater percentage of nurses (38%) compared with CEPs (28%) making up the cardiac rehabilitation team (6).

In closing, we would like to reiterate that the development and expansion of DCEP programs is one element among a larger strategy to propel the CEP profession forward. We must take lessons from other allied health professions that have already transitioned and experienced great success. The CEP plays a prominent role in today's health care system, but we have yet to meet our potential and therefore need to raise expectations and take innovative steps forward.

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