Field Technical Service
IT Laboratory Automation
Customer Technical Support

Who we are
At Roche, 79,000 people across 150 countries are pushing back the frontiers of healthcare. Working together, we’ve become one of the world’s leading research-focused healthcare groups. Our success is built on innovation, curiosity and diversity, and on seeing each other’s differences as an advantage. To innovate healthcare, Roche has ambitious plans to keep learning and growing—and is seeking people who have the same goals for themselves.

Who you are
You’re someone who wants to influence your own development. You’re looking for a company where you have the opportunity to pursue your interests across functions and geographies, and where a job title is not considered the final definition of who you are, but the starting point.

The positions
We currently have openings available, and frequently add other openings, within our Field Technical Service, IT Laboratory Automation and Customer Technical Support areas based in the field throughout the United States and also at our U.S. headquarters, based in Indianapolis, IN.

Roche is an equal opportunity employer

“Make your mark. Improve lives.”

Matt F.
Roche, USA
Last year ASCP developed a communication strategy to accomplish three goals:

- Raise awareness of the value of ASCP to pathologists and laboratory professionals
- Raise awareness of the value of pathologists and laboratory professionals to the broader medical community and the public
- Develop mechanisms for ongoing dialogue between and among ASCP members and other key audiences.

ASCP reflects the future of health care, uniting pathologists and laboratory professionals into a team serving the health of individual patients and the public. What distinguishes ASCP is our inclusiveness, our size, and our commitment to work for the public good. Pathologists and laboratory professionals work behind the scenes to provide accurate diagnoses and data on which treatment decisions are made. It’s important to let people know.

This issue of Critical Values reports on new ways that ASCP is reaching out to different constituencies and suggests ways in which individuals can do the same. The first step in the ASCP communication strategy is the creation of a network of ASCP spokespersons to represent the Society and the profession to the news media and the public. The new media spokespersons for ASCP are introduced on page 16, and plans are discussed for raising awareness of the profession throughout the year and during National Medical Laboratory Professionals Week. Also featured are successful efforts and useful strategies for communicating with nurses in your hospital (p. 18), legislators in your state (p. 22), and students in your school district (p. 13).

Communicating scientific information when knowledge and technology are in flux can be tricky. The rapidly changing environment surrounding the human papillomavirus (HPV) test and vaccine and their impact on the Pap smear poses such a challenge. ASCP has a responsibility to inform and educate members and the public about issues that affect them, even when experts disagree. Such divergent views are presented beginning on page 24, along with numerous resources for further investigation.

As always, some of the challenges associated with communicating critical values are explored—in this case, the confusion in defining “critical tests,” “critical results,” and turnaround time (p. 34). Arts in Culture presents an excerpt from an award-winning poem written from the perspective of a breast cancer patient (p. 33).

Critical Values is now one year old. This newsmagazine has become an important way for ASCP to communicate by exploring substantive issues in a conversational tone and encouraging further dialogue. We start the second year by adding a regular feature: leadership messages from the ASCP President, Chair of the Council of Laboratory Professionals, and Chair of the Resident Council.

Dr. McKenna is president of ASCP.
Departments

About Critical Values  3
Your Letters  6

Leadership Messages
ASCP—Helping Laboratorians Help Patients  8
Barbara J. McKenna

Focusing on Students, Our Future Leaders  11
Lynnette G. Chakkaphak

Out of the Laboratory and into the World:
Residents Must Lead the Way  14
Ahren C. Rittershaus

Arts in Culture
From ‘Cancer Winter’  33
Marilyn Hacker

Critical Values
Understanding National Patient Safety Goal 2C:
Clarity Brings Compliance  34
Terri Yablonsky Stat

Communication
Sharing My Passion  13
Mary Ann Hrisinko

Meet the ASCP Media Spokespersons  16

Bridging the Gap between the Lab and ED Nurses  18
Christina P. Nickel

Anatomy of an Advocacy Campaign  22
Shaun Hill

Pap and HPV: Two Perspectives
HPV Vaccine to Transform Testing Protocol,
Profession Sooner Rather than Later  25
Mark H. Stoler

Not So Fast: Pap to Remain Screening Centerpiece
for Foreseeable Future  28
R. Marshall Austin

ASCP News  32
OJT versus CLA

Ms. O’Neal’s letter in the October 2008 issue of Critical Values (Vol. 1, No. 4, p. 6) regarding on-the-job training (OJT) and the clinical laboratory assistant (CLA) certificate was very timely for me. Last week I met with the managers of our city’s two largest laboratories, one of which is the local hospital lab, the other a large clinic lab. Both are experiencing a shortage of MTs and MLTs. One solution we are examining is to train phlebotomists to become “lab assistants” and do more of the waived and moderate complexity work, supervised by the remaining technical staff.

Rather than in-house training, however, we, the local community college, would like to provide a “Lab Assistant” course to train the phlebotomists in those tests, as well as lab safety, terminology, quality control, and other laboratory basics. This would alleviate the employers’ burden of designing, delivering, and documenting a training program. However, the employers desire some type of outside agency certification of their training. Unfortunately, there is no longer a good level of certification for individuals with the skills mentioned.

I would be very interested if any of your readers are aware of certifications available for laboratory assistants. I would be much more interested, however, if the ASCP would consider bringing back the CLA credential. ASCP has always been the “gold standard” for laboratory certification, and there is certainly a need to recognize and certify all those individuals who are doing the work and filling in the gaps left by retiring techs.

Nancy G. Worsinger, MS, MT(ASCP)
Lead Instructor, Allied Health
Nash Community College
Rocky Mount, NC

OJT Won’t Work for Me

While [on-the-job training] may sound like a good idea “on paper,” I have to wonder how practical it is in consideration of the work force shortage and the fact that we are lucky to get the testing done, let alone try to train someone at the same time. It is hard enough training a new person with a college degree and some practical experience. The thought of trying to train someone off the street is just not acceptable. It might work in a very large facility that has the luxury of an education and training staff, but that is not possible in any of the facilities I am familiar with.

John C. Staley, MT(ASCP)
Transfusion Service Supervisor
McKay-Dee Hospital Center
Ogden, UT
The Elephant in the Room

I have been in some form of medical care delivery for almost 40 years. For nearly 20 of those years I was a clinical microbiologist. I got out of the laboratory business not because I didn't like the work. I loved being a microbiologist. The bottom-line truth was I could not make a living. Plus room for advancement was small. I have found that no one wants to deal with the heart of the issue, that is, the economic role of the pathologist in the laboratory. The economics are such that the pathologists are too highly compensated for the work that they do. Let’s look at this from another angle. The pharmacists have no MD supervision. The physical therapists have no MD supervision. Their compensation is twice that of a medical technologist. As long as the structure of the lab is under the pathologist, the economic depression for medical technologists will continue. This is the elephant in the room that no one ever seems to want to discuss.

James D. Hamilton, M(ASCP)SM, MBA, FACMPE
Principal Executive
Somerset Health Care Group
Spencerville, IN

Shortage Is All about the Money

It all comes down to recognition and salary. Why don’t the lab managers and pathologists take on the hospital administrators and get our salaries commensurate with our responsibilities? I speak at high school medical skills classes and am a member of the school district Medical Skills Advisory Board. I give pros and cons of working in a lab, but am honest about the salary issue. Until I can go into the classroom and proclaim that these jobs are respected and financially rewarding, I can’t see an end to the shortage. Until the information about lab careers is introduced at a national level to pique the interest of science students, this shortage will not go away.

Julie H. Sinclair, MT(ASCP)SC
Farmington Hills, MI

Great Issue, Great Timing!

I came across this great issue of Critical Values because we are writing a Community-Based Job Training grant from the Department of Labor to expand and build the capacity of our Histo and MLT programs. This grant supports workforce training for high growth/high demand industries by building the capacity of community colleges. What great timing to find this issue!

Tyler M. Winkler
Resource Development Officer
Florida Community College
Jacksonville, FL
Leadership Messages

Message from the President

Kalyani Naik, CT(ASCP)SCT
Suntea Hammer, MD
Maegan Hillman, HT(ASCP)
Jonathan McHugh, MD, FASCP
Elizabeth Bauer M(ASCP)
We must not, in trying to think about how we can make a big difference, ignore the small daily differences we can make which, over time, add up to big differences that we often cannot foresee.

—Marian Wright Edelman
President and Founder of Children's Defense Fund

What is the American Society for Clinical Pathology all about? The answer to this question depends on whom you ask.

Two Different Perspectives

Many members perceive the Society as an education organization offering a variety of workshops, educational courses, and assessment activities. Others focus on the publications—two professional journals, this magazine, and a variety of superb textbooks. Others identify with the ASCP Board of Registry because they are proud of their certification. Still others appreciate the Society's extensive advocacy efforts and its foreign and domestic humanitarian activities.

In contrast, members who are active as volunteers—those serving on and perhaps even chairing ASCP committees, commissions, task forces, or boards—give yet another answer. It is one that comes from having the broader perspective of those actively involved in leadership. These individuals state that ASCP is a not-for-profit organization that exists to serve the public good.

These views can be seen as two different perspectives. One perspective is of ASCP as a membership organization that exists primarily to serve members through education and certification. The other perspective is that the Society's primary purpose is defined by what is in the best interests of the public health. There is a similar duality in the perspectives of pathologists and laboratory professionals regarding their professional lives.

The Unexpected Dichotomy

In more than 20 years as a practicing pathologist, I have worked beside scores of dedicated pathologists and other laboratory professionals. Again and again I have seen their willingness to go the extra mile, take the extra step, stay late, arrive early, or continue to be available from home when a patient's well-being is at stake. There are little thanks for those who work with such dedication and compassion. Clinicians are sometimes aware of the extra efforts, but patients certainly are not. Thus, the motivation of these tireless professionals appears pure. It seems their primary motivator is, in fact, to help patients.

To test this hypothesis, I asked a number of current and former colleagues, including pathologists, medical technologists, cytotechnologists, and histotechnologists, the following questions:

• Why did you choose your profession? For pathologists this question had two parts: Why did you decide on medical school, and then, why did you choose pathology?
• What part of your profession drives you, gives you the greatest satisfaction, and makes you want to get up and go to work?

Given my observations on laboratory professionals’ exquisite attention to patient care, I thought the answers would center on a desire to help people. Instead, 80% of the pathologists I talked with cited an interest in science and a desire for intellectual stimulation as their reasons for going into medicine and pathology. The remaining 20% cited a desire to help people. Interestingly, most of the latter group consists of international medical graduates.
The technologists were more evenly split, with about half of them listing an interest in science and half of them expressing a desire to help people.

In response to the second question, 80% of everyone I asked cited intellectual satisfaction and the opportunity to face new challenges and learn new things as their primary motivators. How can this apparent contradiction be reconciled? On the one hand there is the strong focus on quality patient care, and on the other hand there are the stated motivators—an interest in science and a desire for intellectual stimulation.

I believe it is precisely the joy of meeting scientific challenges and searching for knowledge that drives most pathologists and laboratory professionals to achieve excellence in patient care. Were they not interested, curious, alert to the unusual, and hungry to learn more, pathologists and laboratory professionals would probably deliver no more than mediocre, uninspired care.

How do the responses of my colleagues relate to ASCP? ASCP is an organization of 130,000 members. If my colleagues reflect the attitudes of the average ASCP member, then the ASCP comprises people who are driven by a keen interest in science, a love of learning, and an appetite for new challenges. In addition, if my colleagues’ dedication to quality patient care can be generalized to all ASCP members, then this is an organization that consists of people who strive to serve patients and therefore the public to the best of their ability.

ASCP’s Ultimate Focus: The Patient

Returning to the original question, What is the ASCP all about? What is the ultimate reason for its existence? Does it exist for the purpose of education or advocacy? Is it a certification organization? Are its humanitarian activities in accord with its underlying mission? Or does ASCP exist primarily for the public good, as its leadership contends?

I believe the answer to all these questions is “Yes!” ASCP educates pathologists and laboratory professionals so that patients and the public can receive the best health care possible. ASCP certifies laboratory professionals to ensure that well-trained, qualified individuals are available to provide needed laboratory services. Likewise, ASCP advocacy efforts focus on issues that ultimately affect the public good. A natural extension of these patient- and public-focused activities is ASCP’s participation in training and certifying laboratory professionals around the world.

In the end, it is each member’s own particular perspective that determines what ASCP is. For the technician or technologist who wants verification of his or her professional qualifications, ASCP is all about certification. For those who join ASCP for its educational programs and products, the Society is all about education. When laboratory professionals respond to an eAdvocacy Alert and write to their state or federal representatives, ASCP is all about advocacy.

On the other hand, taking a step back and looking at everything ASCP does on so many fronts, it becomes clear. Ultimately, the Society’s broad range of activities focuses on ensuring quality health care through uncompromisingly high standards of laboratory medicine. ASCP helps real people in real laboratories help real patients. And that is something about which we can all agree.
Focusing on Students, Our Future Leaders

By Lynnette G. Chakkaphak, MS, MT(ASCP)

Laboratory personnel shortages are already widespread, but over the next decade these shortages could mushroom to critical levels. In June 2008 the ASCP Task Force on Communication responded by identifying high school, community college, and university students as key targets for ASCP communication. The need to reach out to students who have an interest in biological sciences or health care is obvious, especially considering the large number of laboratory professionals who are baby boomers. Their average age is 49.2 years, and approximately 40% of them could retire within 10 years. Thus, it is essential that the laboratory professions be marketed to young people.
Find Ways to Reach Out

Talk to a 14-year-old about the possibility of becoming a physician or nurse, and he or she is likely to conjure up positive images of smart, compassionate caregivers. Suggest a possible career in medical technology, cytology, or histotechnology, however, and he or she will probably stare blankly. Even parents are frequently unfamiliar with laboratory careers.

Wouldn’t it be great if that blank stare could be replaced with the image of a confident, knowledgeable health care professional—an individual who has an interesting scientific career contributing to the diagnosis and treatment of nearly every human disease. This professional would have a secure job with the opportunity for advancement and, because of high nationwide demand, would be able to work almost anywhere.

How do we go about building this image? The Council of Laboratory Professionals (CLP) is asking that same question. One of the Council’s goals for 2009 is to strengthen its connection to students and laboratory education programs in all 50 states. ASCP volunteers serving as Local Representatives are being asked to serve as liaisons to every accredited phlebotomy, cytotechnology, histology, pathologists’ assistant, and medical technology and technician program in the United States. Developing ties to these educational programs at the local and regional levels should promote ASCP student membership and develop a relationship with students and program directors. The Council hopes to support both the programs and the students by reaching out to them and engaging them in new ways.

In 2007 the CLP developed an ASCP Student Handbook in CD format; the handbook was applauded by students and program directors because it provided a great deal of useful information. Building upon the success of the first edition, the 2008–2009 Student Handbook provides information on everything from resumes and career-building to ASCP National Student Honors Awards and ASCP scholarships.

An additional way for CLP to connect with students would be a new ASCP Student Council, which would further engage students and identify better ways to meet their present needs as students as well as their future needs as young professionals entering the field of laboratory medicine.

Build Positive Images

You can build positive images of laboratory professionals in the minds of young people. Dr. Kay Doyle offered a variety of ideas in her article “What You Can Do” in the October 2008 issue of Critical Values (Vol. 1, No. 4, p. 10). One recommendation was to make presentations at career day events. Lasting impressions can be made with very little effort. Put on your white lab coat and take along a few props. You might grab students’ attention by bringing a microscope and some interesting slides for viewing. Parasites, blood smears, tissue slides, or Pap smears are always popular. Consider conducting a brief hand-washing experiment using students from the audience. Plan to leave behind the sealed petri dishes for students and teachers to observe. Contact your ASCP Local or Regional Representatives to borrow a PowerPoint presentation on laboratory careers or get other great ideas.

Here are a few more recommendations:

- Download or order career materials from the ASCP Web site.
- Distribute these materials to advanced biology teachers at high schools in the community. Offer to set up a classroom demonstration that introduces laboratory medicine to students while reinforcing a unit of classroom instruction.
- Find out if any high schools in your district have Health Occupations Students of America (HOSA) programs. If so, contact these groups and ask how you can become involved. Serving as a speaker at a HOSA meeting or offering to give the group a tour of your laboratory would be a great way to raise awareness about laboratory careers.
- Mentor a junior high or high school student working on a science fair project. High school students interested in projects that involve bacteria or fungi are required to work with a qualified scientist in a laboratory setting.

To ensure the success of laboratory professionals in future years, we must reach out to young people today in every way possible. We must promote a clear and positive image of laboratory professionals that attracts students interested in scientific and health care careers. If we are successful, then perhaps when we ask our 14-year-olds what they want to be when they grow up, some of them will answer, “I want to work in a medical laboratory.”

Ms. Chakkaphak is Laboratory Services Director, St. Vincent’s Medical Center, Jacksonville, FL.
By Mary Ann Hrisinko, MT(ASCP)

I have been a medical technologist for more than 31 years. Needless to say, medical technology and hematology in particular have been a major part of my life. In 1972, I had no idea that medical technology existed, but I always enjoyed solving puzzles and doing logic problems, so it was only natural for me to gravitate toward mathematics and science courses.

Two popular television shows in the late 1960s and mid-1970s, Medical Center and Marcus Welby, MD, aroused my interest in medicine (although I must admit so did James Brolin and Chad Everett). Through these television programs I learned of the existence of “the lab” and the inability of physicians to treat a patient without a “lab result.” Lab results were something like a puzzle, and I could solve puzzles. I looked through my college course catalog and stumbled upon the career path of a medical technologist. This sounded much more interesting to me than a career in nursing, so that’s the path I chose.

School Career Days

Two years ago, pathology resident Hillary McElligott, MD, and I attended Career Day at the Eberhardt Elementary School in Chicago. We had no idea what to expect and were amazed by the efforts of this school to introduce its seventh graders to a variety of career paths. We were among lawyers, state attorneys, pediatricians, architects, dentists, and state police officers, to name a few. We each gave a five-minute introduction to our jobs. Then the floor was opened up for questions.

The top two questions for Dr. McElligott and me were: How much do you make and how many hours do you work? We were pleasantly surprised but also stunned, as we were somewhat convinced that nobody from the group would ever want to pursue a career in pathology, especially after hearing about the others.

We were excited when the school asked us to participate in Career Day this year. Our goal this time was to convince the group that a pathologist was a real physician and that a medical technologist did more than draw blood, although I pointed out that a proper blood draw was critical to testing. Dr. McElligott referred to the television program CSI and described the pathologist as the “doctor’s doctor.” It was only natural that I referred to the medical technologist as “the pathologist’s pathologist.”

Nowadays, most children have had their blood drawn, so they can easily relate to the various colored tubes used for collection. I talked about what the colors meant and what tests could be performed on each. I was still asked how much money I made and how many hours I worked, but this time I stressed that you can’t put a price on saving somebody’s life. For some of the children, that hit home. I actually received some lovely letters from the students.

‘Big Yellow Taxi’

It would be a shame if we let our profession become extinct by not providing support for the medical technology programs in colleges and hospitals. Remember the Joni Mitchell song “Big Yellow Taxi”? Institutions seem intent on “paving paradise” and creating “a parking lot” of laboratory professionals with limited expertise. If the “seasoned” technicians are sent to “a museum,” I guarantee it will cost more than “a dollar and a half just to see ’em.”

Seasoned technologists are needed in the laboratory to teach newcomers what they missed during their internship. We need to promote ourselves as professionals. Unfortunately, sometimes we are not viewed as part of the medical profession because we lack direct patient contact. That’s a shame, since I cannot think of a patient contact more direct than distinguishing a malignant from a benign process within blood, fluid, or bone marrow of a patient.

I told the students they are our future and any one of them might be the person who develops a test or cure for leukemia or cancer. It brought a tear to my eye when one of the students said that this was the first time anyone ever referred to them as “their future.”

I encourage my fellow technologists to embrace opportunities to promote our profession. We need to ensure that the younger generation will have the opportunities that we had to become registered medical technologists with the support from organizations such as ASCP.

Ms. Hrisinko is Technical Coordinator, Hematology/Bone Marrow, at Northwestern Memorial Hospital, Chicago.
Out of the Laboratory and into the World: Residents Must Lead the Way

By Ahren C. Rittershaus, MD

As I begin my year as Chair of the ASCP Resident Council, I am cognizant of the great honor and huge responsibility passed on to me and members of the Council. A great deal was accomplished last year, but further action...
and development are required. While some members know me well, many others do not. Let me begin with a brief biography.

I grew up in Malden, Massachusetts, a city outside Boston, and I am a huge Boston sports fan. I also root for the Virginia Tech football team (VT is my wife's alma mater). I completed my undergraduate studies at Johns Hopkins University in Baltimore, Maryland, and continued my southern trek to Richmond, Virginia, where I received my MD from Virginia Commonwealth University School of Medicine, formerly the Medical College of Virginia. I am currently a fourth-year resident in anatomic and clinical pathology at the Medical University of South Carolina in beautiful, historic Charleston.

Transitioning to Service Provider

I joined the ASCP Resident Council during my first year of residency and almost immediately became involved in ASCP activities. My extensive participation afforded some incredible opportunities to grow my pathology knowledge base. It also helped me realize that we, the next generation of clinical pathologists, are entering a profession that has changed dramatically over the past 15 or 20 years and such changes are likely to continue. Today it is not enough to be outstanding diagnosticians. For our profession to remain a viable specialty, pathologists must also become indispensable consultants who work closely with clinicians and are in frequent contact with patients.

I had the privilege of serving on the ASCP Task Force on Communication, which completed its work last June. Our efforts picked up where two previous task forces, the Task Force on the Future and the Task Force on Facing the Future, left off. As a result of the findings of these two task forces, an important underlying theme of the recommendations of the Task Force on Communication was that laboratory professionals, particularly pathologists, need to be much more visible and accessible as health care providers.

This means getting out on patient floors, meeting face-to-face with physicians and patients to explain test results and diagnoses, and being proactive in contacting clinicians to offer consultation services. It is our job to know about the newest diagnostic testing modalities, and it is our responsibility to pass this knowledge on to patients and colleagues so it is used effectively. It also means setting ourselves up as a source of information for legislators and government regulators as well as the media—not only to deal with questions about quality laboratory testing but also to provide background information on specific diseases, diagnostic implications, and treatments.

Becoming Indispensable

Residents need to embrace and lead this transformation, helping the laboratory shift away from its traditional behind-the-scenes role as a “black box,” where patient samples enter and data exit. Instead, the laboratory must become a visible, full-service diagnostic consultation practice. Being indispensable means providing a unique and valuable service, not only data. Data is a commodity that can be bought and sold. By providing a valued service, we become more than a commodity—we become indispensable. Soon clinicians will think they cannot perform their work without us. We are highly skilled and knowledgeable individuals who can synthesize the clinical, radiologic, and pathologic findings into a diagnosis and make cogent recommendations. ASCP is a leader in pathology education, with a wide range of educational products, live meetings, e-courses, and publications and, as such, is ready to help us make this crucial transition.

My number one goal as Chair of the Resident Council is to increase resident involvement in the Society. There are innumerable ways to become involved, including the ASCP Resident Liaison Network and the Resident Council itself. To learn more, visit the ASCP Web page for residents (www.ascp.org/MainMenu/residents.aspx). I can be contacted through that page. I would like to hear about your concerns and the issues affecting you and your residency training program. Most importantly, ask me how you can become more involved in ASCP.

Dr. Rittershaus is a fourth-year resident in anatomic and clinical pathology at the Medical University of South Carolina in Charleston.
Meet the ASCP Media Spokespersons

Barbara J. McKenna, MD, FASCP
ASCP President
Associate Professor of Pathology, University of Michigan Medical School; Director of the Surgical Pathology Fellowship Program, and attending physician, University of Michigan Hospitals, Ann Arbor, MI
Expertise: Gastrointestinal pathology
Liver pathology
Residency and fellowship training in pathology
Pathologist certification and maintenance of certification

Mark H. Stoler, MD, FASCP
ASCP President-Elect
Professor of Pathology, Cytology and Gynecology; Associate Director of Surgical Pathology and Cytopathology; University of Virginia Health System, Charlottesville, VA
Expertise: Pap smears and cervical cancer screening
HPV test and vaccine
Molecular testing

John E. Tomaszewski, MD, FASCP
ASCP Vice President
Professor of Pathology and Laboratory Medicine, Interim Chair, Anatomic Pathology, Hospital of the University of Pennsylvania
Expertise: Genitourinary, immuno, and kidney pathology
Transplant pathology

C. Bruce Alexander, MD, FASCP
ASCP Treasurer
Professor and Vice Chair of Pathology and Pathology Program Director, University of Alabama Medical School, Birmingham, AL
Expertise: Forensic medicine
Pulmonary diseases
Graduate training of pathologists and laboratory professionals

Dave Glenn, MT(ASCP)CM
Chair, ASCP Communications Committee
CEO, Pathology Services, P.C. North Platte, NE
Expertise: Laboratory staffing shortage
Recruitment, retention, and qualified testing personnel
Kathleen (Kay) Doyle, PhD, MT(ASCP)CM
Member, ASCP Communications Committee
Professor, Program Director, and Chair of the Department of Clinical Laboratory and Nutritional Sciences, University of Massachusetts, Lowell, MA
Expertise: Blood banking
Cardiovascular and pulmonary diseases
Laboratory staffing shortage

Jo Anne B. Edwards, MEd, MT(ASCP)
Member, ASCP Communications Committee
Reno, NV
Expertise: Laboratory Management
Laboratory coding
Phlebotomy

Irina Lutinger, MPH, MASCP, H(ASCP)DLM, FACHE
Member, ASCP Communications Committee
Senior Administrative and Director of Clinical Labs, NYU Langone Medical Center, New York, NY
Expertise: Information technology
Laboratory automation
Laboratory staffing shortage

Andrea Bennett, MPH, MT(ASCP)
ASCP Senior Program Manager for Public Policy, Washington, DC
Expertise: Policy
Workforce

Kathleen Becan-McBride, EdD, MT(ASCP)CM
Chair, ASCP Board of Registry Board of Governors; Member, ASCP Board of Directors
Director of Community Outreach & Education, University of Texas Health Science Center, Houston, TX
Expertise: Phlebotomy/blood collection for patient safety

LoAnn C. Peterson, MD, MASCP
Member, ASCP Communications Committee; Member, American Journal of Clinical Pathology Editorial Review Board; past ASCP president
Paul Steiner Professor of Pathology and Director, Hematopathology Section, Northwestern University Feinberg School of Medicine, Chicago, IL
Expertise: Hematopathology

Anna M. Moran, MD, FASCP
Member, ASCP Communications Committee; Ex-Officio, ASCP Fellow Council
Cytopathology Fellow, Drexel University College of Medicine/Hahnemann Hospital, Philadelphia, PA
Expertise: Cytopathology, anatomic pathology: breast cancer, lung cancer, molecular cytopathology
A SCP opens its 2008–2009 media campaign to raise awareness of pathology and laboratory medicine with the introduction of a media spokespersons network. The spokespersons, who will represent the Society to the news media and public, are select ASCP officers, members of the new ASCP Communications Committee, and one ASCP staff member who is an ASCP-certified medical technologist who continues to work part-time in a hospital laboratory.

Throughout the year, and especially during National Medical Laboratory Professionals Week (Lab Week), ASCP spokespersons will tell the story of pathologists and laboratory professionals—the unsung heroes working behind the scenes, solving medical mysteries, and providing essential information for disease diagnosis, treatment, and monitoring. These spokespersons will raise the visibility of rewarding careers in pathology and laboratory medicine, one of the fastest growing fields in health care today. In these tough economic times, students are looking for careers with prospects for growth and long-term stability.

Technology is changing the way diseases are diagnosed and treated, and pathologists and laboratory professionals are in the best position to explain how and why. Molecular testing, laboratory informatics, and the electronic health record will be hot topics, and ASCP spokespersons will share their expertise in these and other issues of compelling public interest.

Spokespersons also will tell the story about how, for example, ASCP is making a difference around the world by providing training and support for HIV/AIDS testing in resource-poor countries, and providing international certification for laboratory professionals in 28 countries.

“Pathologists and laboratory professionals provide an essential service to health care, and yet few people know who we are or what we do,” said Dave Glenn, MT(ASCP)CM, chief executive officer of Pathology Services, P.C., in North Platte, Nebraska, and chair of the ASCP Communications Committee. “Seventy percent of the information used in diagnosing and treating patients originates in the laboratory. It is time we look up from the microscopes and analyzers and let the public know the value we bring to health care.”

Lab Week is scheduled for April 19–25, 2009, and “Laboratory Professionals Get Results” is the theme. This is an excellent time for all members to build on the theme and deliver the good word about pathology and laboratory medicine within both their hospital and their community. ASCP’s Lab Week Planning Guide is now available and has numerous ideas and resources for a successful celebration. Additional resources are available at www.ascp.org/MainMenu/laboratoryprofessionals/LabWeek.aspx.

The new Communications Committee, an outgrowth of the Task Force on Communication, is charged with ensuring both the short- and long-term implementation of the task force’s recommendations. Members for the 2008–2009 year are Glenn; Kathleen (Kay) Doyle, PhD, MT(ASCP)CM; Jo Anne Edwards, MEd, MT(ASCP); Irina Lutinger, MPH, MASCP, H(ASCP)DLM, FACHE; Anna Moran, MD, FASCP; and LoAnn Peterson, MD, MASC.
Bridging the Gap between the Laboratory and ED Nurses

By Christina P. Nickel, MHA, MT(ASCP)

“You don’t want to deal with the laboratory staff. They’re unreasonable.”

What can be done about this type of impression? It’s pretty easy to simply disregard these comments. However, if laboratory employees want to be viewed as medical professionals, this isn’t the way to achieve it.

Solutions to these issues can improve working relationships. More importantly, they can also save lives. Why shouldn’t laboratory professionals develop solutions? Medical technologists are problem-solvers by nature; it’s what they do. At the laboratory at Saint Francis Medical Center, Grand Island, Nebraska, we found that the solution was to bridge the communication gap with nursing. What began as an opportunity to improve relations with the emergency department (ED) became what is now called the Laboratory Liaison Partnership.
A Strained Relationship
At one time, the laboratory did not have what most people would consider a good working relationship with the ED, or with any other nursing department for that matter. Nevertheless, the relationship with the ED was by far the most strained. Constant problems ranged from complaints about prolonged turnaround times to rejected nurse collections.

Although many issues troubling both nursing and the laboratory could be resolved easily, no initiative had been undertaken to address them. Attending the ED staff meeting seemed to be the most effective way to start the process. The laboratory director was surprised, to say the least, that anyone would volunteer for such a colossal challenge; nonetheless, she agreed that it was necessary.

Emergency nurses are, simply by the nature of their profession, very to-the-point, matter-of-fact, “don’t mess with me, I’m here to get the job done” people. Thus the ED nurses were very hesitant to have a laboratory employee attend their staff meeting. Even before anything was said, they were grimacing like they were about to have a root canal.

After introductions, one of the first items discussed was the role of medical technologists and their educational background. Then creating a liaison to the laboratory and the benefits for the ED were discussed. The ED nurses were assured that this process was not for reprimands or lectures, but instead a means for taking any concerns to the laboratory and helping address them.

Liaison Process
Previously, if a nurse identified a problem, he or she would speak to the ED Clinical Coordinator, who would pass the information on to the ED Director, who would then speak to the Laboratory Director, who would pass it on to a Laboratory Clinical Coordinator, who would then determine who could address the situation, unless he or she needed further clarification on the issue, which would take even more time.

With the new liaison process, an ED nurse can directly approach the liaison with a concern. Depending on the severity of the issue, the liaison can either address it immediately or pass it on to the appropriate person. ED nurses were told to contact their liaison via phone or e-mail or even to visit the laboratory if they preferred, at any time, for any concern. Suddenly ED nurses and laboratory staff became partners in health care.

The suggestions, questions, and comments began to surge in. “What number are we supposed to call to talk to a technician?” “How long should it take for someone to come draw labs?” “Why won’t the laboratory accept a specimen I collected at the patient’s bedside but labeled at the nurses’ station?” “I think we need blood culture bottles stored in the ED.” “We need the laboratory to bring the blood to the ED instead of checking it out in the blood bank.”

Many of the questions were easy to answer; some were more challenging. Often, addressing the issue involved education. After a couple months of meetings, the nurses were pleased to see the liaison at their meetings, and the suggestions, questions, and comments turned into, “The lab’s great—you all are doing a great job.”

Redesigned Patient Report
For situations that couldn’t wait, the ED Clinical Coordinator or Director was able to contact the liaison immediately. In one instance, a request was made that the format of patient reports printed in the ED be changed. The ED charts are on clipboards, and unfortunately, the patient demographics appear at the top of the printed laboratory report, so the names are covered when they are placed on the chart. At least once, a laboratory report was filed on the wrong chart. The physician reviewed the results, and the patient was nearly treated based on another patient’s results. Fortunately, the error was caught before any treatment occurred, and as a result, a potentially serious problem was identified.

The request that the demographics be placed at the bottom of the report was submitted to the Clinical Coordinator/LIS specialist directly from the liaison. After one phone call to the ED Director to determine which demographics were needed at the bottom and what information was to remain at the top, the changes were made within an hour of the request. It was amazing how many questions or concerns could be solved as simply as this one. Sometimes the request for change cannot be accommodated because of procedural issues or policies, but meeting with the department provides a venue for discussion and explanation of those situations.

Laboratory Specimen Collection
One situation that did not change policy but did create an opportunity to explain the rationale for the policy was the age-old question, “Why won’t the laboratory accept a specimen I collected and labeled at the nurses’ station, even if I know I drew it from that patient?” Nurses are what many view as grey, compared to the rather strict black-and-white view of medical technologists; again, it’s the nature of their work. Nurses sometimes (maybe most of the time) have to make do with what they have. Medical technologists, on the other hand, have procedures that must be followed; most of the time there are no exceptions. They even have procedures about how to write procedures! Nurses respond much better to explanations of what can result from doing it the “wrong” way, than to a directive such as “because that’s the way it is.”

The explanation that regulatory agencies such as The Joint Commission require specimens to be labeled at the bedside, a description of how many specimens are submitted to the laboratory for testing, and how many of those are mislabeled gave the nurses a better understanding of the requirements. Once the repercussions for a mislabeled specimen and the seriousness of the outcome for the patient were explained, the nurses understood why they needed to label the
specimen at the bedside and also why the laboratory would not accept specimens labeled at the nurses’ station. Another situation that was addressed through the liaison process was contaminated blood cultures collected by nurses. In addition to implementation of a new site preparation procedure for all blood culture collections, the nurses were instructed on the best process for collecting specimens and avoiding contamination. The results were monitored after the instruction, and there was a drastic decrease in the incidence of blood culture contamination, from a 15.5% contamination rate in April 2006 to a 4% rate in August 2006 and 0% in December 2006.

Laboratory Liaison Partnership
After several months of work with the ED, the process was expanded to the intensive care unit. At this point, one person was serving as the liaison to multiple departments, a situation that did not allow for special one-on-one attention. The ultimate goal was to designate one medical technologist to each nursing unit/floor. The Laboratory Liaison Partnership (LLP) was created to meet this goal.

The LLP now has a mission statement, a welcome/invitation letter, and questionnaire, which are sent to the director of the department and forwarded to other managerial personnel as requested by the director. The laboratory liaisons meet once a month to determine the information that needs to be presented to assigned departments and to share information about the progress they have made with assigned departments. Laboratory employees who are not on the team are encouraged to provide suggestions to the LLP for their departments. The LLP has now been expanded to all nursing areas, and the new goal of the team is to expand it to other ancillary services as well. This partnership has not only created a one-on-one experience and improved relationships between the laboratory and nursing departments, but it has also created an avenue for sharing information and for troubleshooting, which ultimately led to better patient care.

The LLP has created a setting for better communication, better relations, better processes, and ultimately a better standard of care for patients. Nurses are comfortable calling the laboratory to discuss a patient’s results, and the medical technologists are also comfortable calling to inquire about a patient’s care that may affect results. They now work together to resolve issues and improve processes, but it is a dynamic process. Some issues that were once resolved evolve into new problems that require some modification. Nevertheless, we have learned from each other, the laboratory from the nurses and vice versa, and the result is improved patient care.

Ms. Nickel is Laboratory Technology Manager at BryanLGH Medical Center in Lincoln, NE. She served as laboratory liaison partnership coordinator in her former position as Medical Technologist with Saint Francis Medical Center in Grand Island, NE.
The importance and relevance of advocacy cannot be understated. Indeed, advocacy is touted as the cornerstone of political action. After all, how can legislators or regulators make informed decisions affecting the lives and livelihoods of the citizenry without input from the electorate? The words bear constant repeating—it is only through participation in the political process that social and economic change occurs, for communities, for states, and for the nation.

This article is a blueprint of sorts, a “how to” based on what ASCP has identified as an important issue to the profession: the laboratory workforce shortage. The first phase consists of education, not only of targeted elected officials but also of the advocates. It is paramount that advocates have a grasp of the subject matter in order to inform those unfamiliar with the laboratory about the issue and to prompt them to take action. Phase two outlines the strategy of the campaign, the actions we are proposing to alleviate the problem. Finally, the blueprint provides examples of the tangible tools needed to carry out the suggested strategy.

The Issue

The overarching problem is that the clinical laboratory workforce shortage is not on the radar screens of policy makers. Pathology and laboratory medicine suffer from a lack of name recognition; few are aware of the critical role of the laboratory in the diagnosis and treatment of patients. The problem is outlined in great detail in the October 2008 issue of Critical Values. It is evident that there is a problem. However, the question remains, What do we want legislators and/or regulators to do to resolve the crisis?

The Strategy

Just as various factors have led to the current and projected shortfall in the laboratory workforce, the approaches to solving the problem must also be multidimensional. Seeking aid from state or federal legislators involves a specific request. Some suggestions are as follows:

- Reauthorization of Title VII under the Public Health Service Act to boost the allied health professions.
- Legislative hearings to discuss the laboratory staffing crisis.
- A proclamation recognizing National Medical Laboratory Professionals Week. Such a gesture, although it would not solve the crisis, would draw attention to the field and create recognition of the contributions of those in the field.
- Funding of laboratory training programs. This funding could be in the form of state-funded grants to schools.
- The creation of a laboratory health services corps whereby students who have received state assistance for their education would be obligated to work in the state for a specified amount of time.

Pursuit of a funding strategy would indeed have the most direct impact on alleviating the workforce shortage; the concern, however, is asking for money. Because of other constraints on state and federal budgets as well as the existing economic downturn, the argument to legislators would have to be extremely compelling.
The Tools

The problem has been defined; solutions have been proposed. The final phase of the advocacy blueprint is to determine the means for achieving the established goals. The typical course of action would be to request a meeting with a legislator or legislative staff member. The request may be a letter, an e-mail, a phone call, or even an electronic form, which is available on many legislators’ Web sites. It may be prudent to call the office beforehand to discern the preferred method of communication.

In the request, identify yourself as a constituent, state your affiliation, and briefly outline what you would like to discuss during your visit. In preparation for the meeting, condense your knowledge of the laboratory workforce shortage into two or three key points, often referred as talking points, that the legislator or legislative staff member needs to understand about the issue. In addition, prepare what is commonly called a leave-behind; this is a more expansive explanation of the laboratory shortage and provides the legislative office with something to refresh their memory about the issue after the meeting.

In meeting with legislators and/or their staffs, either at the state or the federal level:

• Remember the interaction is simply a conversation; do not feel intimidated. You have the body of knowledge and the proposed solutions. You are there to educate and persuade.

• Your meeting may be brief, particularly if you are meeting with members or staff in Washington, DC; expect to have 5 to 15 minutes to make your case. If meeting in the district with your congressional representative or senator, you will probably have more time, just as you would if you were meeting with a member of the state assembly or legislature.

• Do not be surprised by the youthfulness of legislative staff members; these are exceptionally bright men and women who really do have the ear of the legislators.

• Stay on message without being curt. If there is time, engage in light conversation about things back home. However, don't lose sight of the purpose of the visit.

• Most importantly, follow-up is everything. Legislators and their staffs are bombarded with requests. Make sure to follow up with a thank you note; remind them of your issue and what you discussed. Offer to provide any additional information or perhaps to take them on a tour of the laboratory. Hands-on education can be pivotal in bringing home the problem and the need for an immediate solution.

The key to any successful advocacy campaign is the advocate. You are in the lab and see the impact of the shortage and its potential impact on health care delivery. As a constituent, you can localize this problem to legislators. Seize the opportunity to shine a light on the field of laboratory medicine and convince elected officials that inaction will only bring harm. Go forth and educate; your profession is counting on you.

Ms. Hill is ASCP Senior Manager for Advocacy and Quality Laboratory Practice in Washington, DC.
Cervical Cancer: By the Numbers

U.S. Cases 2004: 11,892
U.S. Deaths 2004: 3,850
Worldwide Cases 2005: 500,000
Worldwide Deaths 2005: 260,000
Sources: Centers for Disease Control and Prevention, National Cancer Institute, World Health Organization

Recent publications have estimated that there may be a 50% decrease in the number of Pap tests in a decade due to HPV vaccines, HPV testing, and altered testing protocols, but this is only a 50% decrease. In the United States alone we perform over 60 million Pap tests annually. Even at a 50% reduction, 30 million tests is still a considerable volume. Simply due to the aging of our laboratory staff, we will easily lose more than half our current testing capacity unless we maintain the cytotechnologist pool through our established excellent training programs.

—Letter, American Society for Clinical Pathology, January 21, 2008


Cervical Cancer: Flags Need for More Pap Tests

HPV Vaccine

New cervical cancer test beats Pap smear

Study questions Gardasil benefits against costs

HPV test provides accurate front-line screening

HPV Vaccine Flags Need for More Pap Tests

In No Hurry to Give It a Shot: Many College Students Hesitant About Vaccine Offering Protection Against Cervical Cancer

Nobel Prize Honors HPV Discovery

One-half of the 2008 Nobel Prize in Physiology or Medicine was awarded to Harald zur Hausen, MD, on October 6, 2008, for his discovery of human papilloma viruses causing cervical cancer.

www.dkfz.de/en/zurhausen/index.html

Public Health Recommendations for Screening and Prevention
www.cdc.gov/std/ hpv/
www.cdc.gov/CANCER/cervical/basic_info/
www.cdc.gov/vaccines/vpd-vac/hpv/

ASCP Resources

More from ASCP

www.ascp.org/pdf/PapTests.aspx


E-course: “Does It Matter? Clinical Implications of Pap Test Interpretations”

ASCP GYN Digital Images

Additional Resources

American Society of Cytopathology Future of Cytopathology Forum
www.cytopathology.org/website/article.asp?id=1604
Pap and HPV: Two Perspectives

The introduction of the human papillomavirus (HPV) test and HPV vaccine has changed the landscape for cervical cancer screening. This change affects many—patients, clinicians, laboratory directors, test and vaccine manufacturers, the cytotechnologists who read Pap smears, the schools that educate cytotechnologists, and the agency that certifies them. Rapidly emerging science, vested interests, and conflicting news reports muddy the view of the road ahead. And experts differ on the nature and pace of change. No single message encapsulates this issue. On the following pages Critical Values presents the view of the landscape from two vantage points.
HPV Vaccine to Transform Testing Protocol, Profession Sooner Rather than Later

By Mark H. Stoler, MD, FASCP

Q. How will the HPV vaccine affect cervical cancer screening?

A. As the prevalence of cervical cancer and its precursors drops because of continued screening and vaccine implementation, the clinically significant disease remaining will be harder to detect. Hence, more sensitive screening tests will be needed. Therefore, the protocol will gradually transition from doing Pap smears first and HPV tests only for triage, to the current situation in which for women older than 30 years Pap and HPV tests are being done together, to the future situation in which HPV will probably be done first and either cytology second or not at all. That’s the road map. However, the rate of that transition will vary with the rate of adoption of HPV testing, the rate of adoption of the vaccine, as well as the clinical trials that show HPV testing is more sensitive and easier to do than cytology.

Yet we’re already driving down the road. European pathologists are somewhat ahead, in part because they’ve never really been that satisfied with only cytology. Then again, despite the incredible success of the Pap, neither are U.S. pathologists. When will that process be complete? Considerably more data will be available in the next five years from head-to-head primary screening trials comparing cytology to molecular testing. Such trials have already been conducted in Canada, Scandinavia, Italy, and England. The data all point toward an HPV-first, cytology-second scenario. Such head-to-head trials have not yet been conducted in the United States. Given that such trials have to be large scale and expensive to be definitive, there will be no national guidelines about changing the screening paradigm for three to five years unless data from outside the United States are used. That doesn’t mean, however, that planning for the transition should not begin. First, it’s scientifically better medicine, and second, it takes a long time to plan and implement these transitions. If pathologists don’t plan for it, the system may well fall apart on its own.

Q. How quickly do you expect widespread acceptance and adoption of the HPV vaccine?

A. There’s a whole psychology of vaccine adoption—early adopters versus those who think early adopters are guinea pigs and who will wait to see what happens—that has to take its natural course. Vaccination for many diseases has been going on for a long time, 60 years, and a great deal is known about how to vaccinate populations. Do I think all cervical cancer will be eliminated in the next 60 years? No. But the reality is that if these vaccines are used, the prevalence of the disease is going to drop to a level where it doesn’t make any sense to screen. While it’s going to take a long time—and I emphasize these are the early times—there will still be some impact on workloads in the near term if women are vaccinated. In addition, and I hope in the not-too-distant future, there will be a vaccine that covers more than 95% of the “bad” HPVs instead of only 70%. If everybody is vaccinated, eventually there will be no clinically meaningful abnormal Paps for anybody to look at. There has to be a plan for that. The medically responsible thing to do is not only plan for it but also promote it and make it happen as soon as possible, because it’s a better overall situation for patients. So what is hampering progress?
The data say the available HPV vaccine is terrific. The current major barrier is cost, and the secondary barrier is abundant misinformation about side effects that don’t exist. Unfortunately, a strong anti-vaccine lobby in this country does not believe in vaccines in general. Their impact seems to be slowing adoption of the HPV vaccine. Every analysis has shown that the vaccine is both safe and cost-effective, particularly for 11- and 12-year-olds. The real long-term systematic process will eventually be similar to the experience with Hepatitis B and other childhood immunizations: The child is immunized, and the adult is protected for life. Eventually adults will not even be considered for vaccination, because all the adults will have been vaccinated as young adolescents. Still, that will be a 5- to 10-year transition or more to become a reality.

Q. What will be the impact on the profession of cytotechnology?

A. There are going to be many retirements, but people will still be needed to do 30 million tests (as opposed to 60–70 million) for quite a while. Then the number of tests being done will decline even more, and that’s the problem—how to attract people to a field clearly perceived to be on the decline? Most cytotechnologists in this country do nothing but screen Pap smears. In my opinion we would not need to do as many Pap tests as we do even today if we screened more effectively. It’s just the unfortunate reality.

If the whole country were doing half as many Pap smears, a smaller workforce would be needed. The average age of technologists is “older” and many are retiring, so there is a need for a supply of people to do the existing work. It’s delicate and problematic. At the end of the day, does the workforce need to be the same size? Probably not. I’m not about lying to cytotechnologists. I’m about informing them and saying that we all have to make plans.

Q. What would you say to cytotechnologists?

A. You’re smart, educated, and essentially master’s-prepared people. You can do a lot of things. If you’re in a laboratory that has a large medical, non-GYN volume, you can do that. You can also get involved with molecular pathology, as well as other areas of the laboratory. You can get involved with management. You can do lots of things besides looking at Pap smears. Some proportion of you will be looking at Pap smears for one to two more decades. Will it be the same number as we need today? I don’t think so. Time will tell.

Dr. Stoler is Professor of Pathology, Cytology and Gynecology, and Associate Director of Surgical Pathology and Cytopathology at the University of Virginia Health System in Charlottesville, VA.
Q. How will the HPV vaccine affect cervical cancer screening?

A. The new HPV vaccine looks promising. Nevertheless, “the proof of the pudding is in the eating,” and that means long-term field experience. The vaccine has not been field-tested for long, and it has not been documented that it prevents invasive cervical cancer. Therefore, many questions about safety and efficacy will be answered much more clearly with longer time in the field. Recall the old adage: “Be neither the first to adopt the new nor the last to give up the old.”

Even the vaccine manufacturers acknowledge that women who are vaccinated will still have to be screened. No responsible body of opinion says that women who get vaccinated will not need to be screened. Furthermore, there are reliable data showing that when the Pap test and the HPV test are done together, this powerful combination test has both very high sensitivity for detecting underlying possible disease as well as specific information (mainly from the Pap test) about the likely character of underlying disease. Thus, combination testing, either HPV reflex testing after Atypical Cells of Undetermined Significance (ASCUS) Pap results or the routine co-testing that has been approved for women older than 30 years, represents a powerful test. I’m quite positive about women electing to get these combination tests; however, neither test is perfect by itself in terms of sensitivity, specificity, or negative and positive predictive value.

Q. How quickly do you expect widespread acceptance and adoption of the HPV vaccine?

A. The best candidates for the vaccine now are girls 9 to 12 years old, so the benefits of the vaccination in that group will not be available for a decade or more. Currently available information indicates that only one-fourth of this age group in the United States has received even a single
vaccine shot. Furthermore, it appears that some high-risk groups are significantly less likely to be vaccinated. Therefore, a major reason not to jump the gun with overly optimistic extrapolations about decreasing high-grade dysplasia rates is that most young girls are not yet being vaccinated. The unknowns are the extent to which vaccination will be administered, how long protection will last, and whether boosters will be needed. One cause for concern is that girls are not necessarily returning for all their shots. So they may receive one shot or two shots but not all three shots. There’s a tendency to immediately start thinking about how to dramatically change screening soon. Much of that discussion is extremely premature and frankly is actually being driven by some of the manufacturers and their surrogates. Data are needed on the impact of the vaccine on high-grade dysplasia rates and invasive cervical cancer. There are no data showing that the rate of dysplasia in the overall screening population is decreasing due to the vaccine.

Q. What will be the impact on the profession of cytotechnology?

A. Unfortunately, many mixed messages are out there. The suggestion that there will be less screening is irresponsible and has substantially come from professionals with longstanding close collaborative relationships with manufacturers. The notion of getting rid of the Pap test is also a bad message, because it can inadvertently encourage women to think maybe they don’t need to be screened at all. It can also undermine the cytotechnologist workforce that’s still needed to perform screening and even inadvertently encourage cash-strapped administrators to close cytology schools, which has already happened. It’s attractive to think there are molecular solutions for everything, but the idea that molecular utopia is close has been overstated. A great deal of confusion results.

Q. What would you say to cytotechnologists?

A. Cytotechnologists should be incredibly proud of the accomplishments of their profession. Given the fact that the profession as a group in the United States is graying and that many are nearing retirement, there are opportunities ahead. I also think that emerging combinations of cytology and molecular testing are exciting. A cytotechnologist at the University of Pittsburgh Medical Center–Magee recently earned ASCP certification in molecular testing. We congratulated her, promoted her, and even gave her a raise! However, there’s an over-enthusiasm by some about pushing the Pap test off the cliff. This is driven mostly by corporate communication messages and also by some well-intentioned people who intuitively believe that molecular methods are the answer for everything. Fewer than 200 cytotechnologists a year are graduating in the United States. The chances are great that there will actually be a shortage of cytotechnologists in the future. So I see cytotechnology as a professional field that offers some very exciting and remunerative opportunities.

Dr. Austin is Professor of Pathology at the University of Pittsburgh School of Medicine and the Director of Cytopathology at Magee-Womens Hospital of UPMC.
A recent survey of ASCP members who are under the Maintenance of Certification (MOC) program revealed that 30% of respondents are unaware of the MOC program requirements. In addition, 35% are aware but have not taken any action so far, and 35% are aware and are taking action. Knowledge of these requirements is crucial for pathologists certified in 2006 or after, as they are now required by the American Board of Pathology (ABP) to renew their certification every 10 years. The new process stresses lifelong learning and ongoing improvement.

ASCP offers a variety of activities, including E-courses, educational courses, and CheckSample 2009 exercises, designed to help meet Part II and Part IV requirements of the MOC program. The ASCP MOC committee is monitoring developments and will keep members informed about the MOC requirements through publications, electronic communications, and the ASCP Web site. The ASCP Education Home on the ASCP Web site is a comprehensive online resource to support and facilitate lifelong learning. Members can manage their transcripts, track completion of MOC requirements, launch online Self Assessment Modules (SAMs), update transcripts upon completion, and print certificates that reflect MOC credits.

“The ASCP is committed to making the whole MOC process as easy as possible for its members, not only by offering a variety of CME opportunities, but also monitoring changes and updates from the ABP and making them known to members, as well as sending e-mail reminders of approaching deadlines, based on each individual's initial exam date,” said Larry Fowler, MD, FASCP, Chair of the ASCP MOC Committee.

CheckSample exercises are available in the following topics: clinical chemistry, cytology, forensic pathology, hematology, microbiology, surgical pathology, and transfusion medicine.

Upcoming Education Courses

**February 18–22:** Gynecologic Pathology: A Practical Surgical and Cytologic Perspective, Dr. S. Silverberg, San Francisco, CA. Member price, $1,129.

**March 1–4:** Review of Current Topics in Blood Banking and Transfusion Medicine, Drs. C. Harrison and G. Ramsey, San Antonio, TX. Member price, $929.

**March 22–25:** Diagnostic Hematopathology: Review and Update of Selected Topics, Dr. J. Krause, Hilton Head Island, SC. Member price, $1,019.

**April 2–4:** Update in Pulmonary Pathology: Contemporary Classification and Diagnosis, Dr. A. Churg, Santa Fe, NM. Cosponsored by Pulmonary Pathology Society. Member price, $869.

April 23–25: Current Issues in Liver Pathology, Drs. J. Hart, L. Yerian, and K. Batts, Fort Myers, FL. Member price, $889.

**April 27–30:** Dermatopathology: Contemporary Diagnostic Criteria and Strategies, Dr. A.N. Crowson, Myrtle Beach, SC. Member price, $1,089.

All ASCP Educational Courses provide Category 1 CME credits, as well as some optional SAM credits. For details, visit the ASCP Education Home at www.ascp.org/education.aspx.
Take the First Step Towards A Brighter Future

Earn Your CLT/MLT to CLS/MT Bachelor's Degree Online

- Gain Personal Satisfaction and Confidence
- Increase Your Earnings and Career Options
- No Campus Visits Required
- NAACLS Accredited Program

Call 1-800-556-4280 or Visit www.clsonline.uc.edu to Learn More Today!

ASCP members could save 8% on their auto insurance with a special member discount.

Get a free rate quote today.

© 2009 GEICO

GEICO members could save on their auto insurance with a special member discount.
Miss the Annual Meeting?
Visit ascp.org/2008AnnualMeeting to listen to the keynote sessions on your computer while looking at the PowerPoint presentations or handouts. You can also save these the “audio-only” files to your iPod or MP3 player.

ASCP Masters and Awards
The ASCP honored eight members with ASCP Masterships at the 2008 Annual Meeting in Baltimore: Ellen Hope-Kearns, PhD, MASCP, SH(ASCP); Nathan Johnson, PhD, MASCP, MT(ASCP)DLM, SC, SLS; Joanna Lurie, MS, MASCP, MT(ASCP); Irina Lutinger, MPPH, MASCP, MT(ASCP)DLM, FACHE; LoAnn C. Peterson, MD, MASCP; Steven G. Silverberg, MD, MASCP; Patrick C. J. Ward, MD, MASCP; Mark R. Wick, MD, MASCP.

Ishwarlal Jialal, MD, PhD, FASCP, received the ASCP Philip Levine Award for Outstanding Research. The ASCP H. P. Smith Award for Distinguished Pathology Educator went to Russell K. Brynes, MD, FASCP. Kent B. Lewandrowski, MD, FASCP, received the ASCP Ward Burdick Award for Distinguished Service to Clinical Pathology. And David F. Keren, MD, FASCP, a past president of the ASCP, was honored with the ASCP Israel Davidsohn Award for Distinguished Service.

Residents Natalia Golardi, MD, and Raja M. Gidwani, MD, were honored with 2008 ASCP Resident Liaison Awards. Kathrina Alexander, MD, and Michael H. Roehrl, MD, PhD, tied for first place in the American Journal of Clinical Pathology (AJCP) Resident Research Symposium Competition. Visit www.ascp.org/MainMenu/residents.aspx

ASCP Around the World
ASCP has received $3.9 million for the first year of its second five-year initiative with the U.S. Centers for Disease Control and Prevention (CDC) to continue working with the CDC to strengthen laboratory services for the testing and monitoring of HIV/AIDS patients in Ethiopia, Guyana, Haiti, Kenya, Lesotho, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, and Tanzania. ASCP needs members who are fluent in French and/or Portuguese to translate education materials, serve as facilitators during in-country trainings, and provide technical assistance in countries that are severely affected by HIV/AIDS. Go to www.ascp.org and click on Global Initiatives.

Lab Week
“Laboratory Professionals Get Results” is the theme of the 2009 National Medical Laboratory Professionals Week, April 19-25. The 2009 Planning Guide is now available. Contact ascp@ascp.org (put Lab Week in the subject line), or go to www.ascp.org, click on Laboratory Professionals, then Lab Week.

ASCP Press
Each month three articles from AJCP will be offered to readers to earn CME credit (one CME credit per article). Articles and the associated examination to document credit will be available online only for three years. ASCP Press recently published Laboratory Safety: A Self-Instructional Text, Cytopathology Review Guide, 3rd edition, and Bone Marrow Immunohistochemistry.
I had “breasts like a twenty-five-year-old,”
and that was why, although a mammogram
was done the day of my year-end exam
in which the doctor found the lump, it told
her nothing: small, firm, dense breasts have and hold
their dirty secrets till their secrets damn
them. Out of the operating room
the tumor was delivered, sectioned, cold-
packed, pickled, to demonstrate to residents
an infiltrative ductal carcinoma
(with others of its kind). I’ve one small, dense
firm breast left, and cell-killer pills so no more
killer cells grow, no eggs drop. To survive
my body stops dreaming it’s twenty-five.

It’s not Auschwitz. It’s not the Vel d’Hiv.
It’s not gang rape in Bosnia or
gang rape and gutting in El Salvador.
My self-betraying body needs to grieve
at how hatreds metastasize. Reprieved
(if I am), what am I living for?
Cancer, gratuitous as a massacre,
answers to nothing, tempts me to retrieve
the white-eyed panic in the mortal night,
my father’s silent death at forty-eight,
each numbered, shaved, emaciated Jew
I might have been. They wore the blunt tattoo,
a scar, if they survived, oceans away.
Should I tattoo my scar? What would it say?

No body stops dreaming it’s twenty-five,
or twelve, or ten, when what is possible’s
a long road poplars curtain against loss, able
to swim the river, hike the culvert, drive
through the open portal, find the gold hive
dripping with liquid sweetness. Risible
fantasy, if, all the while, invisible
entropies block the roads, so you arrive
outside a ruin, where trees bald with blight
wane by a river drained to sluggish mud.
The setting sun looks terribly like blood.
The hovering swarm has nothing to forgive.
Your voice petitions the indifferent night:
“I don’t know how to die yet. Let me live.”

From Winter Numbers by Marilyn Hacker
Copyright © 1994 by Marilyn Hacker
Reprinted by permission of Frances Collin, Literary Agent

Ms. Hacker is professor of English at City College of New York.
This is an excerpt from “Cancer Winter,” first published in The
Paris Review (Issue No. 131, Summer 1994). The poem also
appears in Hacker’s book, Winter Numbers (W.W. Norton &
Co., New York, 1994). For “Cancer Winter,” Hacker won the
John Masefield Memorial Award from the Poetry Society of
America and the Bernard F. Conners Prize for Poetry by The
Paris Review. Winter Numbers won the Lambda Literary
Award from the Lambda Literary Foundation and the 1995
Lenore Marshall Poetry Prize of the American Academy of
Poets and The Nation for the most outstanding book of poetry
published in the United States in the previous year.
Understanding National Patient Safety Goal 2C: Clarity Brings Compliance

By Terri Yablonsky Stat

Many laboratory professionals struggle to interpret The Joint Commission's National Patient Safety Goal (NPSG) 2C. Confusion surrounds the definitions of critical tests and results and turnaround time. In brief, NPSG 2C requires that laboratories measure and assess, and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Critical test result refers to both the results of a critical test and to test results with critical values. Hospitals need to make a distinction between critical tests and critical results.

As defined by The Joint Commission, critical tests (often referred to as stat tests) are those tests that will always require rapid communication of the results, even if normal. The time interval to be measured is that from ordering the test to reporting the result to a clinician who can act on the result.

Critical results, also known as critical values, are test results that fall significantly outside the normal range and may represent life-threatening values (e.g., panic values or red-line values) even if from routine tests. Measurement is the time interval from the identification of the critical result to receipt by the responsible licensed caregiver.

“The hospital should establish by policy a list of its critical tests and critical results and the expected turnaround time,” says Margaret Peck, MS, MT(ASCP), executive director of the laboratory accreditation program at The Joint Commission. “The Joint Commission does not determine what diagnostic tests and procedures should be defined as critical. This decision is left to the hospital and its medical staff. Neither does The Joint Commission determine responsibility for or frequency of monitoring turnaround time. A practical, justifiable list, however, will minimize the monitoring resources required.”

A Broader Perspective

The terms critical tests and critical results are not limited to laboratory tests. According to The Joint Commission, these definitions also apply to any imaging studies, electrocardiograms, or other diagnostic tests defined by the organization as critical. All areas of the hospital that perform these tests must monitor turnaround time (TAT).

“The scope is much broader now,” says Jack E. Garon, MD, chair of pathology at Mount Sinai Hospital Medical Center in Chicago. “Monitoring TAT moves outside the lab in a way that is patient-focused. I think it’s a bit uncomfortable for staff but a good thing for patient care.”

Each organization has its own way of establishing its list of critical tests. “We asked people at other hospitals,” says Anthony Kurec, MS, H(ASCP)DLM, administrator, University Pathologists Laboratory at State University, New York Upstate Medical University, Syracuse. “The bottom line is if you identify too many critical tests and choose to monitor them, it becomes a full-time job.”

Most people are monitoring one or two crucial tests, Kurec says. Because it can be difficult to track down a provider for follow-up, his laboratory’s policy identifies key people to whom laboratory staff can report a result if they can’t reach a doctor.
“I would suggest periodically sampling a few records for the required reporting interval, focusing on high-volume or problematic tests first,” adds Peck. “If you have some evidence of occasional monitoring of this interval and action taken when a problem is identified, that will be satisfactory for compliance.”

Defining Turnaround Time

“Many people fall into the trap of thinking in the lab silo,” Dr. Garon says. “The lab may handle the specimen only for a portion of the time, so laboratories consider the TAT only what happens in the lab. But the larger institution, namely, the hospital, has responsibility for the entire TAT.

“For critical tests, if an institution is measuring only the time in the lab, then it is not measuring the whole TAT,” says Dr. Garon. “The clock starts when the test is ordered and ends when the results are in the hands of a licensed caregiver. The lab might not be responsible for all aspects of TAT, but the larger hospital is responsible for the whole TAT.

“In my institution, tests in the emergency room are drawn by nursing, so delays in the pre-analytical phase are unlikely to be caused by the lab. Those delays are still part of the turnaround time, and the institution needs to measure and improve it. The institution should look at the different phases of TAT—pre-analytic, analytic, and post-analytic—separately, because that’s a good way to identify problems. The lab might contribute data on only two or three of these phases, but often all the data are captured by the laboratory information system.”

Challenges Posed by Chronic Conditions

Hospitals are challenged by patients with chronic conditions who have abnormal values as defined by the hospital but are within the “normal” range for that patient, says Denise King, RN, MSN, CEN, president of the Emergency Nurses Association. For example, if a patient is admitted with diabetic ketoacidosis, 400 mg/dL or higher may be a critical value on a blood glucose test. There is going to be a period of time when the patient’s sugar is higher than that critical value.

“The hospital must be able to articulate a policy that anything higher than that value is not going to be a critical value for that particular patient,” King says. “If a blood sugar is done every 30 minutes, you don’t want to call the doctor several times a day to report these values when it isn’t necessary.” The Joint Commission allows for this as long as an organization has a policy stating when critical values in chronic patients need to be called back.

One way to overcome this is to raise the threshold of critical results. “Studies show that by changing thresholds, such as in the dialysis clinic, hospitals can decrease unnecessary phone calls to doctors and costs,” says Kurec.

Another approach would be to customize critical values based on which department orders the test. “Lots of doctors would like critical values to be more customized for their patient populations,” says Karin Olson, MT(ASCP), program associate for quality, University of Iowa Hospitals and Clinics, Iowa City.

But that’s not so easy for nurses. “From the nursing perspective, the more a hospital can standardize the process of reporting results from department to department and test to test, the more success they will have,” says King. “Nurses work in more than one department. The process should be the same regardless of the department.”

Other Challenges

Once the laboratory staff reports a critical value to the licensed caregiver, the hospital must have a mechanism for evaluating when the physician actually received the information and when treatment or action was taken, says Olson. “Once the licensed caregiver has the critical value report, it is sometimes difficult to identify in the patient’s chart the action taken as the result of a critical value report. The appropriate action can vary depending on the patient circumstances or condition.”

Olson’s laboratory tries to avoid multiple exceptions to the critical values calling policy. “Introducing multiple exceptions into a process creates more opportunities for staff to forget or confuse the exceptions,” she says.

Ideally, a laboratory information system would have the ability to have multiple critical value lists based on location or service unit, Olson says. “Having a computer system that can flag critical values based on different sets of parameters or rules is more reliable than having humans trying to remember all the different rules.”

Ms. Stat is a freelance health writer based in Northbrook, IL.
Try our disposable biohazard waste containers and your days of looking at grungy reusable buckets are over. For a free sample, call us or go to our website. www.whitneyproducts.com/benchtop

1-800-338-4237