Message from the Chair of the Council of Laboratory Professionals

By Jack A. Hager, MT(ASCP)SBB

A Seat at the Table:
The Future of Medical Laboratory Professionals as Collaborative Partners in Patient Treatment and Care
One of the memories I have of holidays gone by is of heading off to my grandmother’s house for dinner. She had seating for eight at the dining room table, and often there would be that many adults. Naturally, we kids were relegated to other locations, such as at a card table set up in the kitchen or with TV trays on an enclosed porch. When I was around 12, the fun of watching my younger cousins’ shenanigans had worn off. I desired to have “a seat at the big table” and to be included in adult discussions about subjects such as politics, health, weather, jobs, and football. When I made my case that I was ready for a seat at the big table, my mother counseled me that it was not likely to happen anytime soon and to be careful what I asked for, because doing so meant someone else would likely have to move away or die. Her advice was to be patient and wait; my day would come.

Deciding to pursue a degree in Medical Technology came with the realization that the profession would include little direct patient care beyond phlebotomy. Like many of my colleagues, I was fine with that. Simultaneously making a living and a difference by providing for patient needs was a noble path, even if there was limited or no direct interaction with patients. What soon became difficult to accept was the ostensible limited input into patient diagnosis and treatment. In hindsight, this view was incorrect because the input I provided was significant; it was simply conveyed through results rather than consultation. Still, decisions made in meetings attended by doctors, nurses, department directors, and administrators seldom included laboratory professionals. There were times, particularly early in my career, when thoughts about not having a seat at the big table returned.

In one of my first laboratory jobs, I was instructed not to discuss patient results of testing with anyone. Understandably, these discussions were not to occur with...
patients or visitors; yet the prohibition extended even to nurses and physicians. Any question beyond “when can I expect my results” was to be referred to a supervisor or pathologist. The correlation between testing and patient diagnosis and treatment was not within the general technologist’s area of expertise. When I asked when I might have the opportunity to participate, the counsel was similar to the advice my mom had given me about the seat at the dining room table: Be patient and wait; that day would come.

Another example occurred soon after I became a Specialist in Blood Banking, when I had the opportunity to attend the facility’s transfusion committee meetings. Postsurgery single red blood cell transfusions given to adults with hemoglobins above 10 mg/dl were not unusual, and it seemed the attending physicians were quite perturbed when asked to justify why the transfusion was necessary. The blood bankers even wondered whether, in some cases, single transfusion rule questioning was avoided by transfusing two units of red cells rather than one. It was not for the blood banker to determine if the transfusion was clinically indicated—even raising the question was not our place. Having years of blood bank experience and holding a specialty did not make any of us a competent medical authority.

Opportunities to have a “seat at the big table” professionally are now becoming more abundant within our respective fields. With an ever-expanding menu of clinical laboratory tests for diagnosing and monitoring scores of diseases, emphasis on reducing healthcare costs, and calls for choosing wisely and testing right the first time, the future of health care is moving toward more collaboration between healthcare professions.

The issues will become more complex and acute as the Affordable Care Act is implemented. Will laboratory professionals have a role? If not, why not? Medical Laboratory Scientists are already technical subject matter experts, know the analytical processes, run the analyzers, interact with the vendors, and troubleshoot instrumentation. Right now, an estimated 60 to 70 percent of decisions on admissions, medications, and discharges are based on laboratory data and patient-specific clinical pathologist consultations—and those numbers are on the rise. So there is an ever increasing need for laboratory scientists, particularly those with business and clinical acumen, specialties, and/or graduate degrees, to be part of the healthcare decision team.

With advancements and variations of diagnostic testing, such as the rapid development of genetic and molecular tests, the need has never been greater for harnessing laboratory professionals’ knowledge. We are certainly able to comprehend and utilize business principles such as operational efficiencies, healthcare cost control, and reimbursement as well as compliance, customer service, and clinical correlations of laboratory tests. Knowledge of clinical correlations to test results, lean concepts, and the business of health care will position graduates for future opportunities “off the bench.”

Physicians and other healthcare professionals directly involved in patient care are challenged to keep up with the rapid growth of new clinical information. Thus, getting advice in addition to the results from laboratories relieves the burden of acquiring further diagnostic knowledge and allows the clinicians more time to focus on disease management. Advanced informatics systems help provide this need and will go beyond the automatic computer-generated comments that are not patient-specific, and often insufficient to guide the clinician. These informatics systems need a network of experts from various subspecialties at diagnostic centers linked by data transmission systems. Professionals are able to assemble the data and apply it to medical diagnoses, thereby reducing the costs associated with healthcare delivery.

Competent laboratory professionals are well positioned to move into areas of responsibility for evaluating data about test performance and providing information for physicians. This includes making recommendations about clinical utility and lean processes to ensure tests are useful, timely, reliable, and cost effective; evaluating blood product utilization for a facility or a health system; determining the validity and utility of new clinical laboratory tests; serving as patient advocates for use of only those tests where evidence of sufficient sensitivity and specificity exists; and performing evaluations of new and complex biomarkers.

The needs and opportunities are there. Why not have seats at the big table?

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