Letters, 10/13

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In-office AP laboratories

A CAP-accredited, multi-department laboratory, with 25 well-trained employees. A full-time staff of four American Board of Pathology-certified pathologists, including one with cytopathology boards. A rigorous quality assurance program involving clinicians and pathologists. An integrated electronic medical record system. Constant communication between administrative, technical, and clinical staff. An active volunteer presence in the community, and participation in a national organization of laboratory medical directors of similar laboratories. Is this a leading community hospital laboratory or a high-performing branch of a national reference lab? No, this is UroPartners Laboratory, the anatomic and clinical physician's office laboratory that I had the challenge of creating in 2005, and have had the pleasure of directing for the last eight years.

Matthew Foster, MD, in "A pathologist's observations about in-office AP labs" (September 2013, page 52), appears to have made a startling number of "observations" without the benefit of actual contact with a well-run physician's office laboratory. He has not visited with or spoken to any of the directors of the country's largest POLs. I would like to dispel some of the myths he puts forward.

Dr. Foster asserts that POLs do not change clinician-pathologist interactions. Although (by my choice) I am not a member of the clinician group, I am fully integrated into the practice. I have easy access to all my clinicians; they have easy access to my colleagues and me, and the communication lines are in steady use for clinical matters. In this new age of molecular medicine, my clinicians trust me to guide them in assessing what new modalities are useful for their patients. Additionally, I attend, contribute to, and am listened to at corporate meetings.

Our turnaround time rivals that of any institution I know of. Metrics are carefully assessed, and more than 95 percent of our anatomic results and 100 percent of chemistry and hematology results are in the patient's medical record within one day after receipt of the specimen. Our UroVysion FISH result turnaround time is better than that of commercial laboratories, and we follow an internal algorithm to limit or prevent unnecessary FISH testing.

It is true that we do not use master's level pathologist assistants for our accessioning and grossing, but I see no need to do so for the type of specimens we receive. We carefully choose applicants with bachelor's degrees in science fields and train them in accessioning, grossing, and administrative lab duties, such as filling supply orders. Most of these lab assistants have specific long-term goals, and we are extremely proud of the energetic people who have "graduated" from our lab to further their education in medicine, nursing, pharmacy, environmental science, and even pathology assistant programs.

Dr. Foster questions our ability to provide rapid peer consultation. This was a consideration from the day the lab opened its doors. We have a documented daily slide review conference, with all our pathologists in attendance. In our early days, when we had fewer on staff pathologists, pathologists from a local academic center joined us for our daily review. At no time have patients been in jeopardy, or results delayed, due to lack of peer opinions.

Taking the above into account, perhaps Dr. Foster would agree that my lab, as well as any similar POL, can provide services at least equal to that in other venues. In addition, our diagnostic acumen and the easy availability of our reports eliminate barriers to integrated patient care. But Dr. Foster also believes that performing anatomic pathology in POLs is based on a business model that is "wrong and unethical." In communicating with my fellow laboratory directors in the Large Urology Group Practice Association, I have confirmed that Dr. Foster has not discussed with any of us his assumption that we are "subservient employee(s) whose professional work serves to enhance a clinician's income." In fact, we are all well-compensated (but not rich) professionals, each with our own type of contractual arrangement, working jointly with our clinicians to serve our patients and our communities at large. We are no different than you, Dr. Foster.

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Fetomaternal hemorrhage

I found the fetomaternal hemorrhage article in the August issue (page 1) very interesting. We have had a big push for FMH testing by flow cytometry. As your article says, there isn't the volume to warrant bringing the test on. Just like your statement that the Kleihauer-Betke test needs competency, the same goes for flow. We have validated the assay, but it is very difficult to validate and it is difficult to be absolutely sure where the gating needs to be on low FMH volumes. If testing is not done frequently enough, the expertise is not there either. There is the problem, too, of not having the test available 24/7 or on the weekends. In addition, it's very expensive. I think the biggest problem is the reimbursement guidelines—Medicare reimburses about $68 for FMH testing. The flow test alone without any tech time included runs about $200 per test—and that is just the reagents. The reagents expire, so there would be tremendous waste and expense to the lab, for which there is no reimbursement. So, until there can be some guarantee that the lab will get paid for 24/7 flow cytometry staffing and the expensive reagents, there is not going to be much success bringing the test live.

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