

# From the President's Desk: Telling our story right from the start

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October 2013—This is my first column, and it's only good manners to introduce myself.

I grew up on a small farm in south-central Nebraska, half a mile outside a town of 80 or 90 people. My parents came from big families and our town was small; half of our neighbors were also our relatives. We worked together, played together, held it together.



**Dr. Herbek**

Winters are cold in Nebraska. Rural public power and running water didn't reach us until I was five or six. I learned as a small boy that trips to the outhouse should be made with intention, especially in winter.

At age nine or 10, I was big enough to help with morning chores. We'd get up at 5:00 am, milk the cows, clean up, have breakfast, and head off to school, where two teachers taught nine grades in two rooms. That was the rhythm of our lives. The cows didn't get weekends off and we didn't either.

If we learned from the outhouse to be intentional, we learned from the schoolhouse to be respectful. When another class was learning, you were quiet. When the teacher spoke, you paid attention and practiced the art of listening.

I was the second in our extended family to go to college. In my junior year, I got a job as a respiratory therapist working nights at the local hospital. A couple months into the school year, one of my patients was found to have active TB. Those who'd had contact with this patient were called in for a scratch test. A radiology technologist friend had access to the x-ray equipment, so we decided to do a quick x-ray instead.

The x-ray revealed a goose-egg-sized lesion in my left lower lung that hadn't been there at my pre-employment physical six months before. Further tests showed a low-grade leiomyosarcoma. Its discovery was unlikely and serendipitous, an argument for guardian angels, and a reminder that life is short. The tumor was removed without complications, although it did lead my girlfriend to decide that I was eligible for "serious boyfriend" status. Jean and I married a year later; that was nearly 42 years ago.

All that history was intended to introduce what I think is important and enlist your support as we set out on this two-year journey.

Pathology requires uncommon discipline and skill. Without an accurate diagnosis, nothing else goes right for our patients. It's a big responsibility.

Most people do not understand what we do and we need to tell them. We need to explain how we care for patients. We need to help our patients and colleagues understand exactly what that means.

One of the proudest moments for our lab team at Methodist Hospital in Omaha occurred when results of the biennial physician satisfaction survey were shared with the medical staff. Our fellow physicians were asked why they chose to admit their patients to Methodist. The first driver was quality of nursing care (no argument there!). The second was access to high-tech radiology. And the third was accuracy of pathology diagnoses. Let's hear it for the CAP Surveys and laboratory accreditation!

As pathologists, we are members of many communities whose members count on us for guidance they can trust. So we volunteer for laboratory-related tasks, educating the staff about blood conservation and transfusion medicine. We give countless tumor board presentations. We volunteer for the Physician Hospital Organization board. We organize multispecialty teams to examine possible test overutilization. We do these things, and we should do more of them, because we need to be a presence—not only in our laboratories but in our hospitals, county medical societies, communities, and states. We need to be visible. Let me tell you how I know.

Ruth is a breast cancer patient who taught me an important lesson. I am her pathologist.

Ruth's intraoperative pathology had looked benign, but the postsurgical sentinel lymph node examination had revealed more cancer cells. An axillary lymph node dissection was indicated. When she came into the breast center for a consult with one of our nurse practitioners, Ruth confided that she was very disappointed.

Because we have excellent relationships with the members of our breast center team, the nurse practitioner was able to describe what my followup examination had involved and explain that not all of her cancer would have been discovered without it. Ruth's second surgery was successful and she is now cancer free. She is a cancer survivor.

I didn't know that Ruth was my patient when we met at a community event some time later, but she remembered my name from the pathology report. "You're my pathologist!" she said, when we were introduced. I was surprised and impressed.

I invited Ruth to visit our laboratory and she took me up on it. I showed her exactly how her cancer had been diagnosed—the accessioning table, the grossing table, the cassettes, the slides, the microscope—the whole nine yards. And the very next day, I received a thank-you note that I will never discard.

"You have a great story to tell," she wrote. "Why aren't you telling it? The complexity of your examination. The process you go through to get an accurate diagnosis. I had no idea. You need to tell your story!"

I had learned early on about being intentional, reliable, and attentive, but I learned something new from Ruth that day. It is not enough that our patients receive the very best care from their pathologists. They have to know they are receiving it and how they are receiving it.

By becoming more visible, we can achieve greater clinical integration and the cultural integration that goes with it. Cultural integration will enable us to share our story, not only with our patients but also with the many publics we serve.□n

*Dr. Herbek welcomes communication from CAP members. Send your letters to him at [president@cap.org](mailto:president@cap.org).*