Anatomic pathology 'practitioner'? Emerging roles for the cytotechnologist

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The CAP has 30 official liaisons to various organizations that attend scientific meetings or designate others to do so. They report to the Standards Committee, which reports to the Council on Scientific Affairs. We periodically publish bits of what the CAP's outbound liaisons hear and see in their liaison roles.

January 2015—As new technology is incorporated into practice and health care reimbursement models evolve, the field of pathology continues to transform. For example, in gynecologic cytopathology, Papanicolaou testing is declining as molecular testing for human papillomavirus is incorporated into cervical cancer screening. This has an adverse impact on daily cytotechnology workload. Simultaneously, decreased reimbursement is affecting pathology practices, and questions have been raised about potential shortfalls in the future pathologist workforce. These potential changes could require increased professional productivity for pathologists. As such, new opportunities arise to discuss ways in which pathologists might redistribute workload to an advanced newly trained allied health workforce.

The Cytotechnology Programs Review Committee (CPRC) recently drafted a proposal outlining a new scope of practice for just such a mid-level anatomic pathology position. The CAP Cytopathology Committee reviewed the proposal and expressed its concerns about the role (as proposed by the CPRC) to the CAP Council on Scientific Affairs. The advanced-level position, as suggested, would represent a highly trained health care professional who would use his or her morphologic skills, understanding of neoplasia, and ability to synthesize clinical and laboratory data to assist pathologists in providing high-quality diagnostic services. Such a professional might extend the current role of the cytotechnologist to involve screening a wider variety of specimen types, collecting and collating clinical information, teaching, and quality assurance activities. Implementation of such a program might be iterative with a progressive introduction of tasks into the current cytotechnologist curriculum as needs and capabilities arise. This additional level of support would allow the pathologist to devote greater amounts of time to the evolving higher-level tasks becoming prevalent in practice today.

The CAP Cytopathology Committee did endorse more limited roles for the new position in four core areas: morphology, molecular diagnostics, digital pathology, and laboratory operations. For morphology support, examples include assessing the adequacy of fine-needle aspirations (provided that a professional fee could be charged for this service; the individuals would not perform rapid interpretation), prescreening special stains for microorganisms, and selecting appropriate material for molecular diagnostic testing. Roles in digital pathology include taking and organizing digital images, such as helping a pathologist prepare for an interdisciplinary tumor board. Functions in laboratory operations could include process improvement, test development, and ensuring regulatory and laboratory accreditation compliance, all under the supervision of a pathologist. Finally, the individuals could play a key role in education—designing, developing, and delivering curricula to other allied health care professions.

The CPRC's proposal, as modified by the CAP Cytopathology Committee, was presented last year to the CAP Council on Scientific Affairs. The council did not endorse supporting this position at this time. However, the CAP has a formal outbound liaison to the CPRC, and ongoing dialogue between the two groups is expected. As market pressures change our overall roles, the CAP and other professional organizations will continue to discuss the creation of a mid-level professional such as this.
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