**Shiftin’ the blame?**

I have just received the August 2007 MLO, and I must take issue with the comments Angela C. Brin, CLS (NCA, MT(HHS)), made concerning her third-shift stereotype comments [Letters to the editor; “Third-shift stereotype?” on p. 7]. I am entering my 44th year of work in the clinical laboratory. I spent approximately 15 or so of those years as a “working” lab director (took night call, worked weekends, etc.) and have just completed my 16th year at my current job on second shift. I gave up the hassle of lab director about 17 years ago.

I can assure you that there are lazy laboratory personnel on all three shifts! I also never try to leave on time to get to the bar; I go straight home and drink my beer!! If these second-shift people she is talking about want to go to a bar, [it] is their business what they do on their own time, and no one else’s.

Anxiously, Ms. Brin has herself stereotyped every laboratory professional, and I think she owes the profession an apology herself! After all, she is only on the third shift.

She is the one who should be ashamed of herself.

—Name Withheld by Request

Angela C. Brin wrote in the “Letters to the editor” section of the August 2007 issue that she felt she had to register her “disgust” at what she interpreted to be a slur against all third-shift workers: “Why did Ms. Harty-Golder find it necessary to malign an entire group of laboratory professionals because of the shift they work ...?” And then she proceeded to malign the first and second shifts. I can certainly see why there’s shift-to-shift discord in her lab!

—Karen Watkins, MT(ASCP)
Huntington Hospital
Pasadena, CA

Ms. Brin is quick to show to what depths she is rankled by what she feels is a back-handed slight to those in the laboratory profession working the night shift, but is startlingly bilious in her portrayal of her counterparts on the other shifts at her institution. I can only imagine the relationship she has fostered over the years with the co-workers [for whom] she shows such obvious contempt. Indeed, she seemed to relish her verbal attack on first- and second-shifters, by whom she gets “treated like garbage.” In the context of her diatribe, “lazy” comes off as flattery relative to Ms. Brin’s portrait of a pampered, self-obsessed, and condescending staff on other shifts. Does she think work isn’t performed when she’s sleeping through the daylight hours in preparation of her next high-pressure shift?

Strangely, she yearns for a time when “laboratory professionals respect each other.” Well, as some (grown-up) “kids” say: Charity begins at home. I’ve worked for 20 years as a medical technologist, primarily on the PM and day shifts, but floating to the night shift for weeks at a time. Each shift has its unique stresses ... and its share of prickly personalities.

Perhaps if Ms. Brin made small attempts at “bridge building” to those on other shifts, she wouldn’t view comments by her co-workers and other professionals in such a harsh light. I just wish you and Dr. Harty-Golder had taken her to task for her hypocrisy instead of going to such great lengths to placate her.

—David Zemke, MT(ASCP)
Transfusion Service Technical Specialist
Mercy Health System
Janesville, WI

**Editor’s note:** One difficult aspect of being an editor or columnist is learning to deal calmly with unhappy readers, not to take angry remarks or frustrations personally, and to allow the “customer” to be “right.” Mr. Zemke’s statement, as well as others shared openly here, will perhaps find all of us — shift workers or not — making an effort to create a better work environment for everyone.

**Loyalty, truth, integrity, and quality**

Dr. Statland’s article, “Ethics: a code for the laboratory” in the August 2007 issue [p. 10] of MLO was absolutely superb. There is no question that the important factors in the laboratory of loyalty, truth, integrity, and quality are most significant. It is extremely well stated. Thank you for printing this wonderful article. What Dr. Statland says about the laboratory applies...
not only to the lab, but everything in the practice of medicine. All physicians need to read this article and be aware of this. I commend you once more.

—Wallace Rubin, MD
Metairie, LA

Editor’s note: MLO thanks Dr. Rubin from the Great State of Louisiana for his comments. We can take credit for reprinting this article, which originally appeared in MLO in June 1995. Ethics never goes out of fashion, although it sometimes gets shoved to the back of the closet.

I read with interest the article by Dr. Bernard Statland in the August 2007 issue titled, “Ethics: a code for the laboratory.” Most of us laboratorians who have been active in the field for several years are well aware of Dr. Statland and his accomplishments.

I would like to comment on one aspect of the article. Under the section on business aspects of the laboratory, he uses the word “commercial” laboratories to describe independent laboratories. This term was used many years ago, predominately by hospital-based pathologists, as a negative description for independent laboratories.

Those of us who are directors or owners of independent laboratories feel that the word “commercial” is misused in such a reference since the term means a business operated for a profit and could also be used to describe hospital outreach programs and physician office labs.

I have been a laboratorian for 50 years and speak out every time I hear the phrase “commercial laboratory” in reference only to the independent laboratory. I will continue to do so in hopes all authors and lecturers will eventually use the terms correctly.

—Alvin M. Salton, HCLD(ABB)
White Lake, NY

Editor’s note: Again, MLO thanks another of its readers, Mr. Salton, for his comments. Since the article to which he refers was originally published 12 years ago in MLO, and since Dr. Statland is now deceased, the editors chose to leave Dr. Statland’s manuscript exactly as it first appeared in 1995, and, thus, erring on the side of caution.

The ongoing experiment

Clinical Laboratories of Hawaii has 15 hospital laboratory sites, 60 patient service centers, and over 900 employees located throughout the state. We have been extensively tracking spurious high potassium values on our patients for seven years.

As you know, the pre-analytical aspects that contribute to this problem are numerous. Imagine what it was like for us. All our efforts to control or eliminate the problem had made little impact. As a result, we were drawing an SST tube as our primary specimen and an Li-Heparin plasma separator tube (PST) as a backup on every patient. If the potassium value from the SST tube was >5.1, we ran the PST. In many instances, the PST showed markedly lower values.

Continuing our research, we came across the article (“Investigating elevated potassium values” by Daniel M. Baer, MD; Dennis J. Ernst, MT(ASCP); Susan I. Willeford, MT(ASCP), and Raymond Gambino, MD, p. 24) in the November 2006 issue. The article mentioned fist clenching/pumping as one of the influences that had a dramatic effect on falsely elevating plasma potassium values due to the increase of interstitial fluid from the forearm muscle.

The experiment described drawing one tube from each arm, one pumped/clenched, and the other relaxed. We had cautioned our staff about this issue before but noted recently that some continued the practice.

But we needed to take the experiment one step further. Could this explain the large difference we were seeing between the first and second tubes drawn? How quickly would the potassium value go back to normal once the hand was relaxed?

We set up a limited experiment with only two volunteers. They were each drawn twice. The first draw was with the tourniquet applied for one minute, hand gently closed, no fist clenching or pumping. The SST was drawn first, followed by two PSTs. The results were unremarkable, all approximately the same [see Table 1].

The second draw had the tourniquet applied for one minute, during which time the fist was pumped, then clenched during needle entry, and then opened and relaxed once blood flow was established. We followed the same order of draw of the three tubes.

As expected, the SST tube showed a markedly increased potassium value compared to the control. This was very similar to the results depicted in your article. It was the results of the second tubes that were astounding to us. The results came almost back down to their normal levels!

We now have evidence that the potassium values will return to normal by the second tube when the hand is relaxed as soon as blood flow is achieved. We think this explains why our first drawn (SST) tube was the one with the high potassium and the subsequent tubes (PST) were normal. It was probably not the fault of the SST tubes (their shipping/storage conditions) or any of the other myriad of pre-analytical influences we had studied.

As a result of these findings, we have directed our staff to stop the practice of fist pumping/clenching. If they have to do this in order to draw a difficult patient, then they must first draw a discard tube.

I hope this information proves of value to your readers regarding this vital issue.

—Barbara H. Barnes, MS, MT(ASCP)
Quality Improvement Manager
Clinical Laboratories of Hawaii, LLP
Ewa Beach, HI

Authors’ reply: Thank you for confirming the relationship between fist clenching and elevated plasma potassium concentrations. Your information about the speed of the drop back to normal concentrations is interesting. Since the timing would depend on when the tourniquet was released and normal blood flow resumed in relation to the drawing of the tubes, one cannot assume that a second tube would always have a potassium concentration that was not elevated.

Table 1.

<table>
<thead>
<tr>
<th></th>
<th>SST</th>
<th>PST-1</th>
<th>PST-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Control arm</td>
<td>3.6</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>#1 Pumped arm</td>
<td>4.9</td>
<td>3.7</td>
<td>3.3</td>
</tr>
<tr>
<td>#2 Control arm</td>
<td>4.1</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td>#2 Pumped arm</td>
<td>4.9</td>
<td>4.2</td>
<td>4.0</td>
</tr>
</tbody>
</table>

The authors are referring to a table with the following data: SST-1, PST-1, and PST-2 with corresponding values for #1 and #2 Control and Pumped arms.