Notes from the Editor

The Responsibility Lies With Us
by Nick Widder, RRT, CRTT, CPFT

The recent incident in California has allowed all of us to contemplate the reasons why we went into this profession. If you’ve been living under a rock for the past several months and haven’t heard the story, a respiratory therapist in Glendale first confessed to, and then recanted, killing more than 50 patients whom he felt were terminally ill and would be better off “put out of their misery.” The most egregious incident in this ongoing saga, however, is the fact that shortly after the story broke, the entire respiratory care department in this hospital was put on temporary leave, and four were subsequently fired.

This situation demonstrates the continued grouping of our entire profession by the lowest common denominator. Unfortunately, the responsibility for raising the level of professionalism in our chosen field lies not with our leaders, managers, or educators, but rather with us, the workers at the bedside — those of us who are, in fact, the backbone of the profession.

Fortunately, I am writing this to a group of folks who have not only joined our professional organization, but have also chosen to demonstrate an interest in adult acute care by joining this section. We, as a group, should use the incident in Glendale to demonstrate the hazards that come with not being accepted as an actual profession, and to do the things in our power to elevate ourselves — by our own bootstraps if we have to — to a point where no other set of administrators would consider the suspension of an entire respiratory department for the alleged actions of just one.

We must realize that the peer pressure necessary to maintain an adequate level of professionalism needs to come from us, not from our supervisors or from our administrators. As the bedside practitioners, we ARE the peer group of which I am referring, and we are responsible for the ongoing “leadership by example” that is necessary to elevate ourselves from the depths in which the Glendale incident has placed us. We can only blame ourselves for not preventing a similar suspension from happening in the future.

Notes from the Chair

Clinical Competency - Are All Big Macs Made The Same?
by John M. Graybeal, CRTT

Are all of MacDonald’s Big Mac sandwiches made the same? If you order a Big Mac on Thursday for lunch, don’t you expect to get a sandwich very much like the one you received on Sunday evening on the way home from the ball game? Why should our patients expect any less? When they are to receive treatment for a particular disease or condition should not that treatment be administered similarly every time no matter who is giving it?

The past few weeks have pre-

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been involved in medical student and resident staff education. I certainly didn’t feel as if I needed clinical competency training, and especially not when it came to caring for young patients with cystic fibrosis. The only thing these patients need are bronchodilators and good chest PT. Right!?

Wrong! So many things have changed in recent years. Developments have occurred in the types of medications delivered in the aerosol form; not only bronchodilators, but mucolytics, antibiotics, steroids, and gene therapy. Methods to deliver chest PT have changed significantly as well — now we have mechanical and pneumatic percussors, intrapulmonary percussive ventilation, positive expiratory pressure valves, flutter valves, ThAlRepy vest, autogenic drainage, and “huff coughing.” These changes allow for a great deal of flexibility and customization of therapy regimens to meet specific patient needs. But they also offer considerable confusion to the patient, the patient’s family, and even the health care team. Training everyone on the team to do everything the same way helps to minimize this confusion.

Remember the Big Mac analogy? In that setting what happens if customer satisfaction drops and people stop buying Big Macs? MacDonald’s is able to evaluate its product clearly because they know that every Big Mac is being made the same. They can change one aspect of the Big Mac — let’s say they decide to add two pieces of cheese instead of just one. They know that all new Big Macs will be made the same NEW way. They can now evaluate whether this change has improved sales of this product. This is a very organized process designed to improve the product throughout the entire organization. It’s what we call “continuous quality improvement.” The most important factor in the process is that MacDonald’s knows that every Big Mac is made the same way.

It’s the same in health care. Let’s apply this model to caring for our cystic fibrosis patients. The only way we can make any reasonable decision about changing the way we treat our patients is by KNOW-ING that every treatment is being given in the same fashion. I’m not suggesting that we all become robots and throw our decision-making skills out the window. Rather, I am saying that we all need to agree that, for example, aerosol therapy with bronchodilators will be given first, then CPT, then huff-coughing, followed finally by administration of inhaled antibiotics. Only after agreement is made and treatment is carried out in that agreed upon fashion can reasonable and educated improvements to the system be made and evaluated.

Recognized clinical competency leads, then, to the development of either formal or informal treatment plans, protocols, or pathways (or whatever else you want to call them). From the development of these plans and their organized evaluation comes “clinical quality improvement,” with the final goal being improved quality outcomes for our patients. In today’s competitive health care market we’re not all that different from MacDonald’s or Burger King. There are only so many people who are going to consume burgers tonight. The goal is to get most of them to consume your burgers and like them enough to come back tomorrow night. Our goal in the health care industry should be the same; provide a quality outcome that the customer is pleased with and is willing to return for if they need care again.

There are four relatively easy steps in developing and implementing clinical competencies. First, a review of the methods presently used to deliver care should be carried out. It is most important to clearly understand the starting point before the group can make the move into clinical competencies. Second, decide as a group the “one” method to be used.
as the starting place. This is not necessarily the “ultimate” method, but again you need a starting place. Third, train everyone in the key elements of the method you have chosen. Organization and consistency are the keys to clear evaluation of the method. Fourth, evaluate both the success of your training and the success of your chosen method. Before you can evaluate the effectiveness of your method and any potential changes you may make, it is paramount that the training you provide be evaluated. Is everyone doing things the same way — the way they were trained? It is natural to be somewhat defensive about clinical competency training and testing at the outset. However, this is the key to developing consistent, quality care for our patients. And after all, isn’t that one of the reasons we entered this profession in the first place — to provide quality care for our patients?

**FYI...**

**Flunisolide/salbutamol combination effective in acute asthma**

Asthmatics who present to the emergency room with acute symptoms appear to benefit more from treatment with a combination of flunisolide and salbutamol than from treatment with salbutamol alone. Researchers from Uruguay found that while measures of lung function and peak expiratory flow increased significantly over baseline for both groups, results for the flunisolide group were significantly different at 90, 120, 150, and 180 minutes post-treatment. What’s more, patients in the salbutamol-alone group who had symptoms that lasted for 24 hours or more had significantly lower FEV1 at 120, 150, and 180 minutes than those in the other groups. (Am J Respir Crit Care Med 1998;157:698-703)

**Antidepressants linked to IPF**

British researchers who studied the lifetime medication use of 387 people age 65 or older have found a link between certain tricyclic antidepressant drugs and idiopathic pulmonary fibrosis (IPF). Significantly more of the 141 individuals diagnosed with IPF had been prescribed antidepressants over the years than the 246 healthy controls. Those who had taken the antidepressant imipramine carried a nearly five times greater risk of contracting the disease, while those who had taken mianserin had over triple the risk and those prescribed dothiepin over twice the risk. (Am J Respir Crit Care Med 1998;157:743-747)

**Palm prints reveal intubation difficulties**

Yale University researchers looking for a way to tell which diabetics might be difficult to intubate due to impaired joint mobility have come up with an interesting predictor. Take the person’s palm print. In a study of 83 adult diabetics scheduled for surgery, they found that taking an ink print of the palm correctly identified joint problems in 100% of the patients. Specifically, those with impaired joint mobility had prints that showed less complete finger areas, thus indicating less mobile joints. (Acta Anaesthesiologica Scandinavica 1998;42:199-203)

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**Outstanding Section Member of the Quarter: Request for Nominations**

Don’t forget to make your nominations for the Adult Acute Care Outstanding Section Mem-ber of the Quarter award. The winner of each Outstanding Section Member of the Quarter award will be featured in an article in the Bulletin and our Specialty Practitioner of the Year will be chosen from these four winners. The winner of the Specialty Practitioner of the Year award will be honored during the Awards Ceremony at the AARC Convention.

The recipient of this award will be determined by the Section Chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the section. Mail or FAX a short (500 words or less) essay outlining your nominee’s qualifications to the chair at the address/number listed on page 2 of this issue. Be sure to include both your name, address, and phone number, along with that of your nominee.

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Editor’s Note: The following survey was developed to solicit information from those of you who would like to be listed on our expert panel, a listing of resource individuals within the section. Panel members agree to act as an information and networking source for fellow section members on topics of mutual interest or concern. Please take a few minutes to fill out the form and mail/fax it to Dennis Hastings, Department of Pulmonary Services, University of Texas Medical Branch, Galveston, TX, 77555.

Name________________________________________________________________________________
Hospital____________________________________________________________________________
Address ______________________________________________________________________________
Phone ___________________________________ Fax________________________________________
Address _____________________________________________________________________________
How many therapists are employed in your acute care setting? ________________________________
What are your current responsibilities in the hospital? ________________________________
____________________________________________________________________________________
Are you using patient care protocols? If so, which ones? ________________________________
____________________________________________________________________________________
Are you currently cross-training your therapists for non-traditional duties? If so, in which areas?_______
____________________________________________________________________________________
____________________________________________________________________________________
What is the current state of your department and in which direction are you heading? ________________
____________________________________________________________________________________
____________________________________________________________________________________
Whom do you answer to?___________________________________________________________
Under whose medical direction do you work?__________________________________________
What is the general environment in your area pertaining to the practice of respiratory care in the acute care setting? __________________________________________________________________________
Are you involved in clinical research? If so, how? ________________________________
____________________________________________________________________________________
What impact has managed care had on the operation of your department and the role of the therapist in the acute care setting?______________________________________________________________________________
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