Notes from the Editor
by David W. Chang, EdD, RRT

Be sure you’re right, then go ahead
– Davy Crockett

As I work on this issue of the Bulletin, my feelings are a mix of “eternal” happiness and brief sorrow. As you may know, my tenure as the editor of the Bulletin is coming to an end in 1998. At the moment, I am happy that I will no longer have Bulletin deadlines to meet. But to be fair, I must admit that the Bulletin deadlines have taught me to become more organized in the things I do. I have also become more proficient at proofreading and in the use of file conversion, scanners, e-mail, copy machines, and the all-important telephone.

I want to thank the publications department at the AARC for doing a wonderful job working with me during these past four years. The pages in the Education Section Bulletin are the result of their skillful proofreading, editing, and formatting of the manuscripts. Throughout the years, they were always available to provide helpful suggestions and correct factual, grammatical, and syntax errors. They are also among the few people I know who can convert files from different (and sometimes obscure) word processing programs, fonts, and page layouts into something usable.

To avoid risking omission of a single contributor to the Bulletin, I would like to offer my deepest and most sincere thank-you to everyone who supported my role as editor of the Bulletin since 1995 by contributing to this publication. Educators, students, and practitioners from coast to coast (including Hawaii, of course, Steve) sent in news articles, original papers, research abstracts, cartoons, humor, and software and book reviews. Their contributions truly enriched the contents and usefulness of the Bulletin. The feeling of sorrow I mentioned earlier stems from the fact that I will no longer have the same kind of regular contact with these special friends and colleagues that I had as editor. But I know my sorrows will be short-lived, as my connections with them will continue in a different fashion.

To our long-time members and readers: you have probably noticed the changes in the format of the Bulletin during the past few years. I hope you have enjoyed reading this publication as much as I have enjoyed putting it together. Now I join you in looking forward to 1999, when Art Jones will begin serving as the editor of the Bulletin. I hope all of you will take an active role in your specialty section by sending in submissions and giving the same level of support to Art that you have always given to me.

1999 Calendar Deadline

March 13, 1999 CRTT Exam......................January 1, 1999
June 5, 1999 RRT Exam ........................February 1, 1999
June 5, 1999 CPFT Exam........................April 1, 1999
Summer Forum Abstracts ......................April 1, 1999
Summer Forum (Phoenix, AZ)...................July 16-18, 1999
December 4, 1999 RPFT Exam...............September, 1999
Hints on Surviving a Self-Study Write-Up and Site Visit

by Bruce Feistner, MSS, RRT, respiratory therapy program director, Dakota State University, Madison, SD.

Counsel woven into the fabric of real life is wisdom.
— Benjamin

Having recently completed a CoARC self-study document write-up and site visit, I thought I’d share some thoughts with those of you who have yet to have the “opportunity” to undertake this task. These are just one person’s thoughts and may or may not work for everyone. The intent is simply to suggest some ways in which program directors can make the process less stressful and more productive.

The goal of the write-up and visit is for programs to look critically at themselves and their product, and find ways to streamline and improve their operations. The self-study document can be imposing, especially if you have never done one. It’s probably not meant to be incredibly challenging, but when you receive your package and notice that the submission deadline is six months away, you get an idea of what is involved in the preparation. Although you may not need the entire six months to collect all the data, the time frame gives you a chance to reflect on what you are collecting, how you are presenting it, and what your data say about your program.

When it comes to the write-up, I suggest that you:

• Put enough detail in the document to answer the questions, but don’t go overboard. If you can answer something in a page and a half instead of padding it for six pages, do it. After you get a few sections done, have another person or two read them to see if they make sense to them. What seems obvious to you may not be to someone else. They can also check for completeness, clarity of the answer, typographical errors, sentence structure, and other helpful items. They may also suggest another angle you may not have considered.

• Don’t be afraid to involve others in your project. It is always tempting to want to do everything yourself, but involving other program faculty, clinical instructors, and staff members allows several viewpoints to be included and makes your product all the more complete. If others are giving you input, you will have more time to pull the whole thing together, consider all the data, and carefully evaluate how the document is proceeding.

• Make sure your sections are clearly marked and easy to follow. Use a three-ring binder of adequate size to allow all your sections to be easily accessed and not overcrowded. Put titles on the tabs of your dividers that are clear and easy to read. Use enough dividers at logical places to make your document easy to follow. The holes punched in your pages, catalogs, brochures, and other inclusions should be precisely drilled so the entries move without binding or tearing.

• Be sure your original typed pages are printed with good quality dark ink. You do not want to have lighter areas that might not copy uniformly. Make sure all pages are legible, all your information is copied squarely onto the page, and all data is included.

• If something could be stated more clearly in a table or illustration, go ahead and include it. Budgeting, staffing patterns, and illustrations of where your program fits into your college hierarchy are examples of things that may lend themselves to this treatment. Remember to reference the table in the written portion so that the reviewer does not have to guess where the table or illustration fits.

• Double-check all your written material, tables, and results. When typing for hours without a break, it is easy to make mistakes and turn numbers around or state something in a less than clear manner. Taking a break for awhile or re-reading the section the next day will do wonders towards helping to clarify the different areas of your write-up.

• Keep track of the documents you collect. You will be collecting data, catalogs, tables of numbers, handouts, and many other items over the course of your
write-up. As you gather your documents, mark them with a note referring to the sections to which they belong, or some other descriptor, so that when you put them in the report a few weeks or months later, you'll know where they fit. Find a secure place to store these collections, because other people may come into the area and reorganize or throw things away, which wouldn't do wonders for your disposition. Organization is the key. Label the information, store it securely, and then remember where you put it.

- **Try to set aside some time every week to work on the project.** That way, you won't be tempted to prioritize other projects higher on your list of things to do, thus inadvertently forgetting about the write-up. Since you are collecting lots of data and organizing a fairly lengthy write-up, allow yourself enough time to do the job. It's like we tell our students - do a little each day, then you won't have to "cram" for the final.

Once the write-up is complete and you've made adequate copies to mail in and keep yourself, it's time to submit the report. Make sure your shipping box is of adequate size and strength to withstand the trip. The label on the box must be clear and complete, or it may end up in the "lost" section of some remote depot. It is always useful to pay a little extra at the post office so you can be notified when the package has been received at the CoARC. Someone signs for it, and you're sent a receipt. You can now relax a bit. Your first big job is over!

But wait a minute! You're not done! Now you have to get ready for the site visit! Preparation for this event may take almost as much time as the self-study write-up. There are lots of details to cover, people to schedule for interviews, documentation to line up, lunches to order, and tours to arrange. Again, having others help you will make the process go much smoother.

You will be sent a list of documentation the visitors might want to see. Keep in mind that this is only a suggested, tentative list, and that the visitors may want to see something totally different. It is important to keep all your records and supporting data organized, so if the team needs to see something unexpected, you'll be ready.

If you need to exhibit several student folders, make sure the documentation is complete and organized in chronological order. The site visitors should be able to open the folder and follow the student through the program, from your first contact with the individual until the person graduated. You will need several types of student folders. You'll probably need an example or two of good students, borderline students, students who flunked out, problem students, and various other varieties that come to mind. The purpose of having all these types of student files is to demonstrate that your program can handle all kinds of students, not just the good ones.

You will probably need a main meeting room where the visitors can talk to the faculty; interview students, graduates, and others; and prepare their write-up. The room should be located in a central location and have adequate lighting and air conditioning. It is a nice touch to consider the comfort of the visitors and have coffee, punch, cookies, etc., available for them. Consider them guests of your program, and treat them accordingly.

You'll need to schedule several groups of people to be interviewed. This may include members of your advisory committee, current students, graduates, program faculty, clinical instructors, department staff, administrators, etc. Contact these groups far enough in advance so they can block out time on their calendars to attend. You can initially make a phone call or send a letter to them, but you should also send a reminder letter or make a follow-up phone call a week or so before the visit. If you lined them up two months before the visit, it is possible that some of them may have forgotten. They will probably appreciate a reminder.

Treat these groups with the same respect you extend to the site visitors. They are doing you a favor by disrupting their day to participate in your site visit, so make it as easy as possible for them to find the room, complete the interview, and be on their way with as little interruption to their schedule as possible. Sometimes a person may only be available by speakerphone. This is acceptable if the person plays a key role in the visit and is unable to physically attend the session. This shows the site visitors that you have done your utmost to have the correct people present to answer their questions.

Try to anticipate the needs of the site visitors. If they're looking at a good student's file, be ready to give them other examples of student files. If there is extra time between interviews, ask if they would like to look at something else while they're waiting. Your attention to their needs will be greatly appreciated.

Schedule the events of the day to flow smoothly into one another. Don't pack things so tightly that the visitors don't have time to catch their breath. It's okay to schedule an hour for an interview and only use 35 minutes. In the remaining time, the visitors can stretch their legs, check other documentation, or clarify points with the program faculty. The events should be scheduled far enough apart so some breaks occur between them, but not so far apart that you have excessive down time. The site visitors only have so much time, and if they can get a visit done in a day-and-a-half versus two, they'll probably appreciate that. Knowing how much time to schedule for each interview, record check, or tour will probably be acquired through experience. You may have helped with a visit, or have records of previous visits, or have actually run one yourself. In any case, the more exposure you have, the easier it will be.

At the end of the visit, you'll attend the summation conference and find out just how good your program really is. If the visitors have suggestions for program improvement, that's great. The purpose of the visit is to suggest ways to strengthen and improve your program. If they notice some things that you're lacking, you have the opportunity to address these issues and correct them. Hopefully, things have gone just fine, and you've passed with flying colors.

Obviously, these hints are not exhaustive, nor do they constitute a complete list of things to consider and do. The process surrounding the self-study write-up and site visit is
Using Situational Leadership to Develop Students
by Jacqueline Rogers, MS, RRT, senior instructor, respiratory care, Palm Beach Community College, Palm Beach Garden, FL

We must develop our leadership styles to match the development stages of our students.

“A process of influencing individual and group activities toward goal setting and goal achievement” (Megginson, 1992, p.458).

“The art and science of getting people to do their work exceptionally well because they want to” (Stevens, 1995).

These are two definitions of leadership that can steer the direction of our students. Good leaders possess qualities that distinguish them from others. A few of these qualities include vision, enthusiasm, a concern for others, persistence, and vitality. However, exceptional leaders are those who can grasp the total situation as it evolves and influence people accordingly. This is the description of a situational leader.

Situational leadership is a “process for developing people by providing effective leadership over time so that they can reach their highest level of performance” (Blanchard, 1994, p.3). Personal observation has shown that having an understanding of human behavior can help one choose the correct leadership style for each developmental stage.

Following any training program, motivation among group members is usually high. However, there may be reluctance to implement new activities without direct supervision. This behavior has been observed in second-year students who are expected to work independently in the clinical setting. The leadership style needed at this time is the supportive style. This style is appropriate because the student, while highly-skilled and competent in most cases, has not yet experienced total autonomy in the care of patients. This can make the student feel somewhat incompetent. The supportive leadership style will provide encouragement for the student to move toward self-reliance with minimal direction.

The situational leader is effective when his or her style matches the development stage of the people or groups of people being directed. Development levels depend on the tasks to be accomplished, and people develop at different stages. When entering areas new to them, even highly-skilled workers have a feeling of low competence. However, if the task or project is a desirable one, their commitment level will be high. Commitment will be demonstrated by high levels of enthusiasm and a high interest level exhibited by attitude, energy levels, and attentiveness. A buddy system where students are paired can help at this development level. Appropriate treatment plans can be discussed, and joint decisions can be made.

As a group’s development progresses, commitment can diminish and disillusionment can set in. Disillusionment occurs from trying to overcome obstacles early in one’s career, as well as from the feeling of being overburdened with work. Expectations of high productivity can be perceived as an obstacle to inexperienced students. These students are required to assess patients and deliver respiratory care within the same time standard as the experienced therapists who are better able to prioritize workloads. Removing obstacles can renew motivation, move people forward, and renew commitment. As the students become more confident, they gain recognition as full contributors to the hospital. High on self-esteem, the group members develop into strong individuals who are empowered to set goals, not only for themselves, but for their patients as well. A leader’s goal is to coach and develop people to their full potential – Registered Respiratory Therapists who, in turn, help their patients achieve their goals, including resolution of breathing difficulties.

Occasionally, the situational leader will observe someone regress in development. This can occur when there is a long lapse in performing certain clinical procedures. The leader must step back in style to influence this person’s development. If the person is still competent, but moderately cautious, a supportive style of leadership will be effective. However, if commitment also falls, a more coaching style will provide encouragement and supporting self-reliant decision-making and problem-solving.

How can we, as respiratory care educators, help our students meet their needs and goals? The answer to this question is to develop leadership styles that match the development stages of our students. Graduating highly-motivated and highly-competent therapists is our goal. At this level of development, self-directed achievers allow program leaders to progress to more of a delegating style because the students have shown that they can act independently and are getting the job done appropriately.

The study of situational leadership can help answer the question of whether a leader is born or made. Based on personal experience, it is my belief that certain leadership qualities are inherent. It is also important to understand developmental behavior stages to enhance the use of effective leadership styles. There is not so much a “right or wrong” style as there is an “effective and ineffective” style, and this is where the leader is made. Situational leadership is the difference between people who only lead or direct and great leaders...
Why Are More Inner-City African-American Children Suffering from Asthma Than White Children?

by Natasha L. Hawthorne

Editor’s Note: Natasha L. Hawthorne was the recipient of the ARCF Morton B. Duggan, Jr. Memorial Education Recognition Award. She was recognized at the AARC International Respiratory Congress last November. Natasha is a student in the respiratory therapy program at Georgia State University in Atlanta. To obtain information about this and other competitive awards for RC students, contact the American Respiratory Care Foundation at (972) 243-2272.

Asthma is one of the most common chronic diseases in the United States, affecting more than 15 million Americans, including five to six million children. (1) This chronic airway disorder is characterized by reversible airflow obstruction and inflammation triggered by hyperresponsiveness to some stimuli. Despite the medical advances in asthma diagnosis and treatment, prevalence and mortality rates are increasing nationally, up 75% from 1980 and as high as 160% among young children. (2, 3) These trends are evident among all races, sexes, and age groups, but there is an alarming increase of occurrence among African-American children.

According to researchers at Rochester General Hospital and the University of Rochester in Rochester, NY, “Inner-city black children have a 45% greater risk of asthma, compared to U.S. children in the general population.” (3) African-American children are also three times more likely to be hospitalized and four to six times more likely to die from the disease. (1) In an age of advanced medical technology and medicine, why are more inner-city African-American children suffering from asthma than white children?

Since asthma is a multifactorial disease, several probable explanations should be examined. The prevalence of asthma has been associated with genetic linkage, socioeconomic, environmental factors, and compliance. All of these factors may contribute to the occurrence of asthma among inner-city African-American youth. As health care providers, respiratory therapists should take an active role in investigating this problem and provide answers for a solution.

According to a study by the National Heart, Lung and Blood Institute (NHLBI), 11 chromosomal regions have been identified as asthma-susceptibility genes. (4) These genes are reported to be linked to bronchial hyperresponsivity and allergic sensitivity. (4) One of most interesting results of the study on the Genetics of Asthma is that of 11 asthma-linked genes, all but one were specific to one ethnic group. NHLBI Director Dr. Claude Lenfant believes that, “the findings provide a possible explanation for the substantial differences in disease prevalence and severity that we have observed among different racial and ethnic groups in the U.S.” (4)

This study consisted of a group of 140 families and, therefore, should be replicated with additional groups to increase validity of the results. Even though no simple pattern of Mendelian inheritance has been identified linking a specific gene with asthma, additional epidemiological studies have shown increased frequency of asthma in first-degree relatives than in control groups. (5) As the study of human genetics progress, other clues may be discovered that provide answers to the etiology of asthma and its increase of prevalence among selective ethnic groups.

Some researchers are skeptical about the increase in prevalence of asthma in certain races due to genetic-linkage and believe, primarily, that the high rate is due to environmental conditions. (3) An exacerbation of asthma can be triggered by inhalation of a variety of environmental factors, such as cigarette smoke, dust mites, animal dander, cockroach allergen, molds, and air pollution. All income groups encounter all of these environmental pollutants, but poor living conditions among low-income children heighten the level of exposure to the allergens.

In Seattle, which has been called the “dust mite capital of the world,” the highest hospitalization rate of asthma was among poor and minority children (five times that of suburban children). (6) In a study that appeared in The New England Journal of Medicine in May of 1997, researchers looked at 478 asthmatic children in eight inner-city locations. Seventy-eight percent were African-American and over half were living with at least one smoker and had bedrooms that tested positive for high levels of cockroach allergens, cat allergens, and dust mites. They concluded that children living in inner cities are exposed to high levels of cockroach allergen and were at higher risk of developing asthma.

In addition to poor living conditions, inner-city African-American children also have higher asthma morbidity due to their socioeconomic status. These children have limited access to quality medical care and lack access to non-emergency care and preventative health

References
care. (6,7) Other factors linked to poverty, such as low-birth weight, illiteracy, and poor health, contribute to the increase in medical complications seen with asthma and other health conditions among this population.

Another probable cause of the increasing prevalence of asthma among African-Americans is lack of diagnosis and compliance. Experts believe as many as one-third of asthma cases in children are undiagnosed. Diagnosis of asthma in children is difficult due to lack of classic symptoms, lack of detailed family history, and poor description of symptoms. (8) Symptoms of asthma are often mistaken for other recurrent respiratory infections and no treatment for asthma is administered. The children are often treated for infections secondary to asthma and severity increases.

In those children who are correctly diagnosed, compliance is essential to the management of the asthma. Patients may not use correct technique with MDI treatments or maintain treatment with corticosteroids because they are asymptomatic. Psychosocial stresses, such as the stigma of being “sick” and having to take medications, leads to lack of compliance. Compliance of state and local organizations with surveillance programs reporting and measuring asthma trends is a problem of great importance. (2) Both the patient and the health care provider effect treatment of asthma from a preventative and management perspective.

Now that some of the probable causes of the high prevalence of asthma among African-American children have been identified, what are some of the solutions to this problem? As genetic research progresses, the answers to whether asthma is genetically linked will help social workers and health care professionals target high-risk groups. Earlier education and environmental and behavioral interventions will result in a significant reduction in symptoms, hospitalizations, and death. (7) With the help of the schools and community organizations, health professionals can pre-screen family history, frequency of symptoms, previous ER visits, and hospitalizations. This valuable information can then be used to classify the severity of asthma according to NIH criteria and implement appropriate asthma management programs that will lead to decreased incidences and health care costs.

A survey conducted by Olsten Kimberly Quality Care revealed that for 257 children participating in an asthma management program, there was a 61% reduction in hospitalization, 46% reduction in physician office visits, and fewer missed school days in comparison to patients nationwide. (9) They estimated an annual savings of more than $11,500 per patient. (9) The Olsten Kimberly Quality Care’s Pediatric Self-Management program involves educating parents and children about asthma triggers and causes, what to do in an asthma emergency, and how to prevent further attacks. This type of prevention and management program could be useful in treating inner-city youth with limited resources and access to quality health care facilities.

Another simple solution to reducing prevalence of asthma is control of environmental exposure to triggers. Pest control, removal of cigarette smoke inside the home, use of mattress covers for dust mites, and air filters can improve the internal environment where the child probably spends the majority of his or her time.

Alternate tablet drug therapy for children who are unable to master the correct MDI technique may increase compliance and drug efficacy. Researchers in Norway who conducted studies using tablet Accolate (zafirlukast) and inhaled beclomethasone dipropionate found that more than half of the participants preferred the Accolate tablet versus 27% who preferred the inhaler. (10) Another report in The Journal of the American Medical Association concluded that the chewable tablet montelukast appears to significantly improve lung function in children with chronic asthma. (11) Participants showed increases of 8.2% with montelukast compared to 3.5% among controls.

At the state and local levels, several programs are already helping to control the increasing epidemic of asthma in inner-city African-American children. The New Jersey Children’s Health Project in Newark uses a state-of-the-art mobile van to provide dependable, high quality health care to disadvantaged children who would not otherwise receive care. (12) This project is funded by the Children’s Health Fund, led by Dr. Irwin Redlener, who believes that “it is critical to develop and implement primary care-based programs that provide state-of-the-art asthma diagnosis, treatment, prevention, and education for children and families.” (13)

Currently, some state governments, such as New York, have proposed legislation that would require doctors and schools to report asthma to public health authorities. (1) This would provide a tracking system to target areas with high prevalence of the disease. Wisconsin and Michigan have developed programs using hospital databases to correlate environmental events and asthma severity, and uncover local incidence patterns and areas of high hospitalization rates. (1) These surveillance programs can be used to establish prevention and management programs in areas where they are most needed.

Respiratory therapists specialize in assisting physicians in the diagnosis, treatment, and management of asthma. In addition to being active participants in implementing care plans for patients, as leaders in the health care profession it is also our responsibility to contribute our knowledge and skills to solving health problems in the community. Asthma is a growing epidemic among inner-city African-American youth, despite the advances in the medical diagnosis and treatment of this disease. This manageable disease may have an increased prevalence due to genetic linkage, socioeconomic factors, and compliance of the patient and health care organizations. Respiratory therapists, along with other health care professionals, can make a significant contribution in enhancing the quality of life for these children through education, pre-screening and surveillance of high-risk patients, intervention programs, alternate drug therapies, and making quality health care available among all socioeconomic groups.
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12. The Children’s Health Fund, Schering-Plough and Children’s Hospital Announce partnership for pediatric mobile medical unit. www.childrenshealthfund.com
13. Dr. J. Redlener. Winning the War on Childhood Asthma: What We Need to Do. www.childrenshealthfund.com

New Product Suggestions

As you know, new product development is an important component of the services that any association provides its members. But where do these new products originate? Quite often they originate with you. You and your staff encounter problems and needs everyday. Perhaps you require an educational product on a procedure or disease. Or maybe you need a manual to help you manage certain components of your department.

Tell us what products or services the AARC can develop that will help you perform your job. We will research your suggestion, and if it is viable, produce it and make it available to the profession.

Please provide the following information when submitting your product or service suggestion:

• Brief description of the product
• Describe who will use this product
• Tell why you believe potential users will buy this product
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