EDITORIALS

The Stethoscope and the Ledger

Respiratory therapy has been something of a phenomenon in modern medicine. Its use in the care of both acutely and chronically ill patients by technical personnel with less than standard medical or nursing training represents a significant and innovative modification of traditional medicine, as an effort to meet contemporary health care needs. The technology was fostered by a relatively small number of physicians interested in new approaches to diagnosis and treatment of pulmonary disorders, but the speed with which demands for its services grew, especially over the past dozen years or so, is testimony enough that it satisfied a strong and widespread need. It soon became evident that there was an insufficient number of physicians available with the expertise to supervise the safe and effective function of respiratory therapy services in average general community hospitals. Most practitioners did not know what services respiratory therapy had to offer their patients, often did not understand its principles well enough to write meaningful orders, and desperately needed expert peer advice from knowledgeable medical directors of such facilities.

The past few years have seen welcome gains in filling the void of medical directorships, as specialty fellowship training programs have been providing the field with graduates of suitable technical and scientific capabilities, and the quality of respiratory care has improved with the ensuing better medical supervision. In the meantime, administrative problems associated with normal growth, but aggravated by increasing economic stress, have reached major dimensions in hospital respiratory care departments. Beset with demands to provide better service at lower cost, and challenged to justify every expenditure and each patient charge, the medical director often finds that medical skills alone are grossly inadequate to help him maintain the structure of his service in a viable and productive state. The reality of this problem in respiratory care and its potentially disastrous effects are described clearly and bluntly in this issue of Chest by Yanda in his article entitled “The Need for Leadership in Hospital Respiratory Services” (see page 81). In a plea for postgraduate education in management for physicians planning to assume medical directorships of respiratory care services, Dr. Yanda cites a startling attrition rate in this occupation. With several brief examples he describes the managerial shortcomings responsible for employment termination. Emphasis on medical and technical proficiency in respiratory care has been the major thrust of postdoctoral education, and it must continue to be, but somewhere in the educational process, time will have to be found to teach potential medical directors how to organize departments of respiratory therapy, operate multilevel educational programs, manage personnel, and budget hundreds of thousands of dollars. This could afford a golden opportunity for some meaningful and productive cooperation between administrators of teaching hospitals and their pulmonary fellowship programs. A specially tailored curriculum of management techniques and problem solving taught by experienced hospital administrators would give the administrators input into the training of the fellows, and enlarge the latter’s perspective of medicine. As a bonus, it might also represent one small step toward reducing friction between professional and administrative staffs, an all too common denominator of hospital medicine.

Historically and traditionally, many physicians have had strong aversions to any activity considered administrative, but this prejudice is now an anachronism and luxury that medicine can no longer afford. The very best respiratory care will never reach the patient’s bedside unless there is a well-founded, well-managed administrative structure to provide both the people and the procedures to carry it there, in the most effective and economic manner.

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