

EVERYONE'S LOOKING FOR HONESTY... IN SOMEONE ELSE

by Leah Curtin RN PhD(h)



I could hardly believe my eyes. There I was, chowing down my bran flakes and reading the morning paper, when I came across an article on the Op-ED page reporting the results of a survey of local employers. It seems that the number one thing that over 400 local employers look for in prospective employees is honesty. The second thing is "someone who will do what I tell them to do."

What a way to start the day! While these two requirements are not mutually exclusive, they often may be at odds with one another! Compare the following:

- A 1997 front page feature article in USA Today headlined "48% of Workers Admit to Unethical or Illegal Acts." However, as you read down the page, it seems that the workers were told by someone in authority to do something they thought was illegal or unethical. And health care workers led the pack!
- A 1995 study conducted by the Ethics Research Center reports that 56% of U.S. Workers have witnessed others lying to their supervisors, 41% have seen other people falsify documents or lie on reports, 35% have seen people stealing company property ... It is, of course, possible, if somewhat unlikely, that the same unethical crooks are observed by large numbers of workers.

It seems that employers want employees to be scrupulously honest in their own dealings, but willing to 'be flexible' when it comes to following directives that are for "the good of the company" or perhaps merely for "the good of the boss!" And I don't think

this double standard is the exclusive preserve of management.

Consider, for example, the following incident. Mary Jane Howe was certified in OB/GYN and she had 18 years of experience working labor and delivery. She was working nights on the weekend - as it turned out, a very busy weekend! They were short-staffed, as usual - and they'd had so many admits that night that

Mary Jane was literally running from one to the next. Among the admissions was a woman in premature labor - and clearly suffering from eclampsia. Her blood pressure was 186/128 - and both she and her fetus were fully monitored. Mary Jane watched her like a hawk. The woman had already lost one infant and she was very afraid that she would lose this one, too.

It was a long night, but they made it through safely. Mary Jane had given report to day shift, and now she was finally sitting down to do her charting. She was late - it was already after 8:00am - and the hospital was really pressuring them to get out on time. Besides, Mary Jane had always hated the paperwork: the important thing was that the patients got good care. Right? So, she hurried through her charting - and when she came to the woman with eclampsia, she didn't bother to get the paper readout from the monitor (who would check something like that anyway?). The long and short of it is, Mary Jane "approximated" the blood pressures - graphing them "pretty close to what she remembered."

As it turned out, when the OB/GYN came in, he did press the readout button - and got the last 10 hours of the patient's blood pressure. And not one single reading jibed with what Mary Jane had charted. The differences weren't huge. In fact, for the most part, they were small - only one or two differed significantly from the monitor's read-out. As it turned out, this particular physician liked Mary Jane, and he did not want her to get in trouble, so he kept his mouth shut. However, a random retrospective audit caught the discrepancy - and Mary Jane was called to account.

No one doubted her competence or, for that matter, her compassion in dealing with patients and families. It was her honesty they questioned. In her defense, she said, "I was too busy taking care of the patient to bother..." But, in actuality, someone else was taking care of the patient when she was charting. It's true, the hospital was trying to cut down on overtime and there was a lot of pressure to get out on time. But how much time would it have taken for Mary Jane to walk a few steps to this woman's room and press the button on the monitor to get an accurate readout? Mary Jane then used her last, best defense, "but everyone else does it, too!" Perhaps, but no one else was caught.

Her co-workers liked her, and the physicians respected her. Moreover, in their small, rural community they had no one to replace her. She was called to the DON's office and reprimanded. She was put on 'probation' but that was it. Perhaps that was the right decision. Perhaps not. But the reality is that Mary Jane is still out there "approximating" observations and data. She does not feel it is 'wrong' and she has no intention of changing the way she practices.

In another case, a pretty infamous one because the nurses ended up accused of negligent homicide, a physician ordered

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increased cardiac muscle content and strength of cardiac muscle fiber, increase in skeletal muscle fiber bifurcation and mass, and increase in muscle mitochondrial mass, allowing increased aerobic metabolism since the TCA cycle and electron transport chain are located in the inner membrane of the mitochondrion.

There are several other methods which can be used to measure the point of anaerobic threshold. Beyond RER, another way of measuring the point of AT is observing a graph of VCO₂ on the Y axis versus VO₂ on the X axis. When the CO₂ production increases at AT, there will be evident a distinct change in slope. This is the point at which lactic acid production increases and marks the beginning of the end phase of exercise.

The best method is to observe the ventilatory equivalents for oxygen and carbon dioxide. We are looking at the rate of breathing as compared to the oxygen consumption and carbon dioxide production. The VE/O₂ and VE/CO₂ ratios are commonly graphed against workload. At the point of AT the O₂ ventilatory equivalent rises and crosses the CO₂ ventilatory equivalent ratio, indicating the onset of metabolic acidosis. The CO₂ production increases in proportion to minute ventilation allowing the VE/VO₂ line to go higher in proportion. A similar graph can be seen for end tidal oxygen and carbon dioxide end tidal measurements.

Arterial line placement is a good but time consuming technique to measure arterial blood gases and lactate during exercise studies. Remember to not place the arterial blood sample in ice slush before analysis as mentioned in my previous article in Focus, March/April issue, page 22. A significant increase in lactate is indicative of the AT. But remember that lactate is made constantly, even during rest. It is completely reasonable to choose not to place an arterial line and instead measure the oxygen saturation through the use of a pulse oximeter. Oxygen pulse, which is VO₂ divided by the heart rate is indicative of normal heart function, as well as high VO₂, normal blood pressure increases, and normal ECG.

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procaine penicillin to be given IM to a newborn infant who had been exposed to an infectious disease. As it turned out, the pharmacist erred in sending up a syringe which contained 10x the dose ordered - and the nurses decided to give the procaine penicillin intravenously rather than intramuscularly. The baby died.

But the point of this story is yet to come. While another nurse and I were discussing this case and its implications, we noted that one of nursings' 'golden rules' is to "give the right medication, in the right dose, at the right time, and by the right route." A third nurse, upon overhearing us, became very agitated and angry. She said, "You don't know what you're talking about. I change the route of administration all the time - and I don't consult anyone! All the nurses in peds do, otherwise the babies would be getting stuck all the time!" "Better stuck, than dead," I sweetly said. "Do you check the PDR before you do it?" "No," she shot back, "and I don't intend to waste the time doing it in the future, either!" She did not feel she was "wrong" and she clearly had no intention of changing her practice.

What's the point? Simply this: we tend to judge others by the results of their actions, and to judge ourselves by our good intentions. This tends to result in a double standard: one for everyone else, and one for me. What's interesting, is that when we try to justify making an exception of ourselves, we tend to do so by proclaiming that "everyone else does it, too! In our line of work that could be deadly!

Dr. Leah Curtin publishes The Journal of Clinical Systems Management, a fact-filled scan of health care in the U.S. She is a member of the adjunct faculty at the University of Cincinnati College of Nursing and is the author of more than 200 articles, 240 editorials and 6 books written for professionals.