Quality Improvement in Respiratory Care Education: Implications for Curriculum Change

To the Editor,

I read the narrative review published by Karthika et al,[1] which described, with great enthusiasm, quality management in respiratory care. I see the implications of this review article to be significant, judging from an administrative point of view. The authors explored the developments relating to the identification of quality measures as well as their implementation in respiratory therapy departments. They also identified challenges related to their enforcement. In addition, they enumerated the 5 key quality indicators for a respiratory therapy department and the importance of ensuring continuous personnel training in quality measures.

Karthika et al[1] mentioned the relevance of formal training but could have, perhaps, expounded more on it. As a quality leader in a premier undergraduate respiratory care program, I write to share my experiences about the subject and to propose the need for the implementation of methods that assure quality improvement (QI) processes toward an effective respiratory therapy curriculum.

Respiratory care education has become an increasingly important item in the health care agenda, which could be the reason why it has undergone profound transformation and reforms of international scale over the past decades, as has been portrayed by Kacmarek et al.[2] In the context of the massive expansion of respiratory therapy education systems, and the associated enhanced participation in the matter, there exist persistent concerns relating to the quality and relevance of preparing the student to evolve as an efficient respiratory therapist. Meanwhile, the standard respiratory therapy curriculum has turned out to be one that steadfastly gets rooted in the reviews of expert respiratory therapy educators. What is worrying is that the relevant faculty members seldom get a chance to examine the multidimensional effects that the erratic review poses on the established goals of undergraduate education.

In traditional respiratory therapy curricula, QI often received passing mention only. However, in the modern curricula relating to new respiratory therapy programs, QI is incorporated into their clinical and nonclinical curricula, to some extent.

It would be judicious for educational institutions to consider training future respiratory therapy professions in QI during their undergraduate studies, with augmentation at postgraduate levels through deliberate formal integration into the curricula.[3]

At present, finding the resources to teach QI during standard respiratory therapy study can be challenging. Perhaps respiratory therapy educators could argue that teaching QI is not necessarily based on prioritizations underpinned by primary importance, or it is impossible to establish in a setting that is characterized by limited space and time to inculcate the core content. My suggestion is that QI lessons should be integrated throughout respiratory care training. Advocating for quality management courses within elective curricula or postgraduate quality management fellowships or certifications allows students to gain QI exposure through educational methods other than traditional classroom lessons.

Indeed, QI ought to be introduced as part of the core curriculum content and not merely sequestered as a component for consideration within a specialty curriculum. Health care institutions could take advantage of the existing values and quality enhancement tactics, which are usually accustomed to respiratory care practitioners that are actively engaged in clinical QI initiatives. The QI process is vital because it helps to enhance understanding of patient experience and discussions about generally acknowledged QI models as well as demonstrate the resources and systems that health care organizations could employ to respond to this information.[4] QI learning should be persistently reinforced through such course delivery mechanisms as seminars, projects, and assignments.

My belief in the strength of QI as a means for the advancement of health care infrastructure and respiratory patient care, as well as the fact that it is tangible and practical,[5] is firm. Integrating QI in the respiratory care curriculum has the potential to expose students to a wider range of opportunities. We must, therefore, see QI appropriateness not only as a future respiratory therapy domain for clinicians but also one that is essential for professionals desirous of leadership/supervisory roles or those whose functions have a positive association with clinical outcomes in the health care system. Incorporating the QI prospectus within the framework of the rest of the core specialty content to be taught in respiratory therapy would make the associated training more pertinent and would sanction the students to assimilate their learning from innumerable contexts. Undergraduate exposure to QI will help students develop an interest in the topic, understand the significance of working as a team, and enhance future application.

QI could be also entrenched by linking it to the performance appraisal of the associated teaching faculty. This is underpinned by the fact that a great educator is one who continuously evaluates the quality of the training that they deliver and also continuously takes measures for QI. Assessments and appraisal of the teaching faculty should consider this as a core element of good practice.[6] Considering all these advantages of QI in respiratory therapy, I strongly advocate that educational institutions, respiratory therapy schools, and universities integrate QI materials in their courses relating to undergraduate, postgraduate, and doctoral programs in health care. The merits of QI to novice respiratory therapists should be viewed by its potential to influence first-line health care provider training. The attainment of this strategy is predominantly anchored on the active reform of the current respiratory therapy curricula.

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