

# Surviving the Clinical-IT Merger: Seven Tips Help Pave the Way

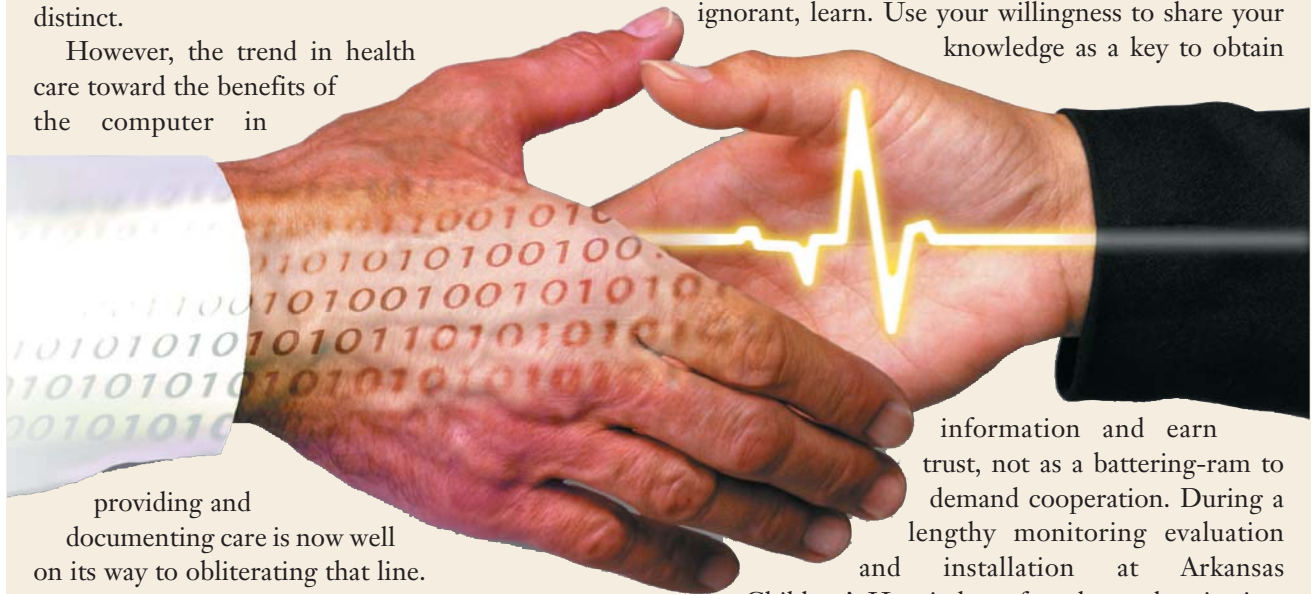
BY BOYD HUTCHINS

Since the beginning of BMET time, pioneers of the field have struggled with carving out an identity for the profession separate from Information Technology (IT). This effort to establish the career as an important benefit to the health care community has been very successful. Facilities are labeling Biomedical Engineering as “clinical,” and rightly so. This has further made the lines separating the Biomedical Technician (BMET) from IT more distinct.

However, the trend in health care toward the benefits of the computer in

listen without being lost. As Jeff Kabachinski, *BI&T* columnist and one of my favorite sources for education, says, “work on an IT knowledge foundation; build an IT info reference library.” Sometimes, just a conversational knowledge can allow you to truly communicate with your vendors and IT departments. Once you speak the language, learning as you go is easily done.

If you are very knowledgeable, teach; if you are ignorant, learn. Use your willingness to share your knowledge as a key to obtain



providing and documenting care is now well on its way to obliterating that line.

The BMET is now often the bridge between IT and the clinician. As this happens more frequently, the question becomes this: “How is a BMET to become effective in a Clinical-IT environment without giving up one’s autonomy?” Here are some suggestions:

Educate yourself and your staff on the basics. Be able to communicate intelligently or at least be able to

information and earn trust, not as a battering-ram to demand cooperation. During a lengthy monitoring evaluation and installation at Arkansas

Children’s Hospital, we found ourselves in situations where the clinical and information worlds collided. By endeavoring to learn of IT’s challenges and to teach IT about the clinical point of view at those points of collision, a solid relationship developed that has had benefits in later projects.

Respect IT’s territory. Understand their security issues and play the game cheerfully. Most IT people have stringent security issues to deal with concerning administrator rights and passwords and this is as it should be. Cheerfully undergo whatever their policy requires to access the network or to set up a personal

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computer. This promotes a feeling of cooperation and gives IT control of their network. We found that our IT department was ready to let us have the space, provided cable runs, switches, etc. were adequately marked.

Set boundaries at the beginning of any installation as to who will be required to maintain the system and who will need access to the components and at what time.

Does the IT staff know that if this monitoring network goes down at 2 a.m. and the BMET does not have access to the switch that they'll be called to open the closet and chaperone the BMET inside? Or does your IT staff know that the BMET cannot maintain the equipment directly and will have to give a vendor access to the server?

Include IT on every equipment evaluation that includes a PC or PC network whether it will be networked directly into IT's data system or not. Many times, IT can offer insights into an operating system or network design that the BMET may not be aware of.

At the very least, IT will appreciate knowing what software applications are installed, who will maintain the system, and what cables are running into and out of their closet conduits.

Value their input and if they would rather not take part in a certain evaluation due to higher priorities or as a matter of policy at least you have given them the option.

Do not let a vendor hold you hostage. Clinical technology mixing with IT is a wonderful thing until vendors use their IT savvy to sell maintenance or software contracts.

The best way to handle this is an agreement between the BMET and end-user to base each software update on its own merits. In other words, "Just Say No to Software" unless it is clinically useful.

This requires that BMETs have a good working knowledge of the equipment so they will be able to discuss the usefulness of the upgrade with the end user.

One department we worked with in this situation agreed that software that decreased analysis time by 3 seconds and offered the color magenta for special waveforms was not worth the cost of the upgrade.

Use PC-based diagnostics when available. Frequently, clinical equipment will come equipped with software diagnostics that the Original Equipment Manufacturer's (OEMs) engineers use to diagnose malfunctions or make adjustments.

Rather than relying on vendors to provide you with service, it is easy given the appropriate equipment to do most of these functions in an in-house shop. If the possession of the software is negotiated at the point of purchase, most vendors will readily supply that information to you in exchange for the sale. By all means, if you

have a laptop and diagnostic software at your disposal, do not hesitate to use it regularly, even if you do so just to remain familiar with logging on to the diagnostic routines of the equipment.

At Arkansas Children's Hospital, we have found that it is cost effective to provide the shop with a laptop and to negotiate diagnostic software into the purchase of the equipment. With the help of our IT department, we have been able to reduce our dependence on the OEM for software reloads, data recovery, and diagnostic routines.

The Clinical/IT merger is happening. How the BMET community responds to it will determine the future of our profession.

We really only have 2 choices.

Either our professions will eventually merge as the technology is doing or the BMET community will embrace these challenges, consider IT a subspecialty, and thrive for years to come. ■

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